S. HRG. 99-305

GRADUATE MEDICAL EDUCATION

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYMENT
AND PRODUCTIVITY

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

EXAMINING THE POSSIBILITY OF AN OVERSUPPLY OF PHYSICIANS AND AN EXCESS PRODUCTION OF MEDICAL AND SURGICAL SUBSPECIALISTS, AND THE RELATIONSHIP THAT THE CURRENT SYSTEM OF GRADUATE MEDICAL EDUCATION HAS TO THESE MANPOWER PROBLEMS

MARCH 25, 1985

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GRADUATE MEDICAL EDUCATION

MONDAY, MARCH 25, 1985

U.S. SENATE,
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY,
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room SD-430, Dirksen Senate Office Building, Senator Dan Quayle, (chairman of the subcommittee) presiding.

Present: Senators Quayle and Simon.

OPENING STATEMENT OF SENATOR QUAYLE

Senator QUAYLE. This hearing has been called to explore in some detail several important physician manpower problems that exist in our country—namely, an oversupply of physicians and an excess production of medical and surgical subspecialists—and the relationship that the current system of graduate medical education has to these manpower problems.

In the process, we shall address the questions whether the Federal Government has a legitimate role to play in solving these manpower problems, and if so, what the role should be.

Specifically, we shall consider whether the Government should use Medicare funds as an incentives for reforming the GME system to make it more responsive to meeting society's needs for more primary care physicians.

I want to make it clear at the outset that our focus is to be the broad policy issues that I have defined. It is not the purpose of this hearing to debate the relative attributes of different payment mechanisms that the Medicare Program might use to reform the GME system. However, these issues must be considered in the context of the reality of the fiscal problems facing the country. We must recognize that the Federal budget deficit and the impending insolvency of the Medicare trust fund mandate that we manage in a more effective way the costs associated with all Government programs including Medicare funding of graduate medical education.

Also, I recognize the importance of the indirect cost issues. I am not in favor of an arbitrary cut in the indirect cost adjustment. I believe that HCFA must develop appropriate methodology to deal with the intensity of illness factor before slashing the indirect cost adjustment. However, this issue is not relevant to our hearing today. We are here today to focus on physician manpower issues and my proposal that the direct cost adjustment be linked to compliance by medical schools and teaching hospitals with manpow-

er—sensitive criteria. I would hope that each of the witnesses would bear this in mind in presenting their testimony.

The manpower issues that we shall be discussing are not new to any of you in this room, nor to the Congress, but I do believe a bit of history is relevant.

During the years 1974-76, an extensive debate took place in the Congress on these very issues. During that debate, a consensus was reached that policies in effect at that time would lead to an excess supply of physicians by the 1990's and that the specialty mix of physicians in training was going to produce too few practitioners of primary care and too many specialists in the medical and surgical subspecialties.

There was a general agreement that as a means of addressing the excess supply problem, the number of foreign medical graduates entering the country for advanced clinical training should be limited.

In order to begin to correct the problem of specialty maldistribution, there was a consensus that at least 50 percent of the graduate physicians should be trained in the primary care specialties of internal medicine, pediatrics, and family medicine. The only real disagreement was on the mechanism by which these goals should be achieved.

There were convincing arguments for either a Federal system to allocate GME positions on a regional basis, or a private/Federal effort to limit the number of GME positions and to allocate positions by specialty. Ultimately, the Congress agreed to allow the medical schools and teaching hospitals to voluntarily achieve these explicit national goals, using capitation payments to medical schools as an incentive for reforming the GME system.

We are here today to readdress these important social issues, since the goals set forth in 1976 have not been met. We continue to expect a significant excess supply of physicians by the end of the decade. In addition, specialty maldistribution has not been corrected. Less than 45 percent of the GME positions in this country are allocated to the primary care specialties. Since almost 60 percent of physicians being trained in internal medicine go on to become subspecialists, only approximately 33 percent of physicians who complete GME training enter primary care practice. Little has changed since the debates of the mid-1970's.

One thing that has changed is that we have much better data. In 1976, the Secretary of HEW empaneled a committee to study these manpower issues and to make recommendations on the basis of the committee's findings. The Graduate Medical Education National Advisory Committee Report was published in 1980. The report projected a significant excess of physicians by 1990 and made estimates of the severity of the specialty maldistribution problem, projecting an excess of most, but not all, specialists in the same timeframe.

Although the report was published 5 years ago, there is little evidence that effective steps have been taken to address the manpower problems highlighted by the GMENAC study.

I hope that the witnesses that will discuss these issues today will shed some light on the current situation and provide us with some

insight into how we might achieve a solution to these important manpower problems.

As I stated in the proposal published in the January 31 Congressional Record, I believe that reform of the GME system is necessary for reasons of policy and as a matter of fiscal prudence. I believe that we must take steps to assure that a larger percentage of physicians train in the primary care specialties in order to achieve a better balance in specialty distribution.

I also believe that we must carefully evaluate our policies relating to graduates of foreign medical schools. In my proposal, I have spelled out mechanisms to accomplish these goals.

I look forward to today's testimony and am willing to work with all interested parties to refine or modify my proposal in order to develop an effective means for achieving a solution to our manpower problems.

[Information supplied for the record follows:]

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 99th CONGRESS, FIRST SESSION

Vol. 131 WASHINGTON, THURSDAY, JANUARY 31, 1985 No. 9

GRADUATE MEDICAL EDUCATION: A PROPOSAL FOR REFORM

● Mr. QUAYLE. Mr. President, it is my intention to work toward a reform of the system of Federal funding for graduate medical education. I believe that this reform is necessary both for reasons of policy—to make the educational system more responsive to the Nation's health needs—and as a matter of fiscal prudence. I have outlined my basic approach below and will welcome comments and suggestions as I move toward turning this proposal into specific legislative form.

Graduate Medical Education [GME] is the generic term for the clinical training that interns and residents receive in the various specialties and subspecialties of medicine. This training is an integral and necessary component of the education of the physician in preparation for clinical practice. At the present time, the majority of States require at least 1 year of graduate medical education for licensure to practice medicine.

Graduate medical education is conducted in the Nation's teaching hospitals. Most GME programs are conducted in the over 400 hospitals that hold membership in the Association of American Medical Colleges' Council of Teaching Hospitals. GME programs vary in length depending upon the nature of the specialty training, but generally range between 3 years, for general internal medicine and pediatrics, and 7 years, for thoracic surgery and other surgical subspecialties.

GME programs have always operated on the premise that the patient care and educational components of the clinical training experience are completely interwoven and thus all program costs should be accepted as a part of the cost of providing patient care. This principle was accepted at the time that the Medicare Program was established in 1965. For the past 20 years, Medicare has paid from the hospital insurance trust fund the costs associated with GME programs. Indeed, until recently, all third-party payers have paid their proportional share of the costs associated with these programs. However, during this time, payers have exercised no influence over the number of training positions, the amount of the stipend associated with each position, or the distribution of positions among the various medical specialties. At the present time, therefore, there is "open-ended" funding for GME programs. Each hospital can determined if it wants to establish GME programs, the kind of specialty training it wants to offer, and the number of positions to offer without any consideration of the costs involved.

The impending insolvency of the Medicare hospital trust fund and concern with escalating health care costs in general have focused attention on the appropriateness of the educational costs incurred by the teaching hospitals. Indeed, the 1982 Social Security Advisory Council recommended that the Medicare Program discontinue paying educational costs from the hospital trust fund. However, the Council recognized that simply defunding GME programs would result in a severe disruption in the system of medical education that exists in this country and thus recommended that Medicare continue to pay these costs until an alternate source of funds could be identified. Along similar lines, the inspector general of the Department of Health and Human Services has recommended that the Medicare hospital trust fund should pay for only the first year of clinical training. According to this recommendation, residents would support themselves in subsequent years by billing patients for the services provided.

I do not believe that either of these approaches are practical if we wish to maintain a system of high quality graduate medical education for the training of physicians in this country. I believe that it would be inappropriate to divorce the funding of GME programs from the revenue that hospitals receive for providing patient care services. Accordingly, I believe that Medicare should continue to pay its fair share of the costs of appropriate graduate medical education programs.

In my view the issue, then, is not whether Medicare will continue to pay GME costs, but whether Medicare will continue to pay in an "open-ended" fashion regardless of the appropriateness of the GME system that exists in this country at the present time. In this context, the focus of the debate shifts from a concern with financing mechanisms to a concern with physician manpower issues.

Since publication of the Report of the Graduate Medical Education National Advisory Council in 1980, attention has focused increasingly on the excess supply and geographic and specialty maldistribution of physicians in our society. As a result, there is a growing consensus that a larger percentage of medical school graduates should be trained in the primary care specialties, rather than the medical and surgical subspecialties. In this context, the Federal Government has attempted during the past decade to promote primary care training, using several different approaches with little success. Presently, the Public Health Service provides grants to help fund primary care GME programs. However, the amount of money distributed by these grants is inadequate to affect significantly the distribution of GME positions among the various specialties.

While I believe that it is appropriate for the Medicare Program and, incidentally, other payers to continue to pay the cost of GME programs, I believe that Medicare should pay only when it can be documented that institutions have responded in a responsible fashion to important societal issues regarding the number and specialty distribution of physicians.

There are three general principles which should be considered in any legislative proposal which would link Medicare support for GME programs with institutional compliance with national guidelines reflecting sensitivity to physician manpower issues. These principles are:

First, there should be an opportunity for every graduate of an LCME-approved U.S. medical school to compete successfully for a position in an approved and funded GME Program. Since GME training is required for licensure in almost all States, we must be certain that every qualified graduate has the opportunity to compete for the training necessary to complete his or her medical education. Recognizing the concerns about an oversupply of practicing physicians and the need to constrain Medicare expenditures, it is important that the number of first-year training positions offered throughout the country approximate the number of graduates of U.S. LCME-approved medical schools.

Second, there is no requirement that each graduate be able to receive training in the specialty of his or her choice. At the present, there is intense competition across the country for positions in the various specialties and in the various teaching hospitals. This is desirable. Individuals who choose to enter medical school must recognize from the outset that society does have a legitimate interest in the specialty distribution of physicians practicing in this country and that the individual may have to accommodate to society's needs when competing for GME training.

Third, education and patient care are completely interwoven in GME programs. Thus, it is essential that the educational component of an institution's GME program must meet uniform standards of quality if the institution is to be eligible for Medicare funds for its GME programs. These standards should be developed by appropriate private sector bodies and applied in a critical fashion when evaluating individual programs. Furthermore, since medical education, in a larger sense, is the responsibility of our Nation's medical schools, each teaching hospital must have an appropriate affiliation agreement with a U.S. medical school that will further attest to the quality of the institution's GME programs. A hospital must not be able to justify maintaining a GME program simply and solely on the basis of the patient care services provided by the physicians in training.

Within the context of these general principles, there are three specific steps which should be taken to address the specific manpower issues.

First: A larger percentage of graduate physicians should enter training in the primary care specialties of internal medicine, pediatrics, family medicine, and obstetrics/gynecology. In order to be eligible for Medicare funds to support GME programs, the majority of positions offered by a single hospital or a group of hospitals sharing an affiliation agreement with a U.S. medical school must be in the primary care specialties. I do not favor allocating positions by specialty because there is useful and desirable variation in the capability and capacity of the teaching hospitals to provide specific forms of training. I would simply require that some majority of all positions, for instance 70 percent, should be allocated to the primary care specialties and the balance to the nonprimary care specialties, without any concern for the distribution of those positions among the various specialties and subspecialties in each major category. All positions funded by patient care generated revenues, including hospital and physician charges, would be counted in de-

termining compliance with the distribution formula. I believe that a private sector body, similar to the Graduate Medical Education National Advisory Council, should be charged with monitoring physician manpower data and making recommendations on the percentage of positions to be allocated to primary care training. These recommendations should be made every 5 years and become operative only after an appropriate time has expired to allow institutions to make adjustments in their GME programs, probably 2 years.

Second: In view of the projections that there will be a substantial excess of physicians in this country by the end of the decade, it does not seem appropriate for Medicare to continue to provide funds in an open-ended fashion for GME training for graduates of foreign medical schools who, by virtue of the training they receive, become eligible to establish practices in this country. Clearly, highly qualified graduates of foreign medical schools should have the opportunity to compete with graduates of U.S. medical schools for GME positions. In order to encourage true competition for positions, Medicare should pay educational costs only when at least 75 percent of trainees in a GME program are graduates of an LCME-approved U.S. medical school.

Third. In order to assure nationwide compliance with these manpower criteria, it is essential that responsibility for coordinating GME programs be vested with institutions that are in the position to negotiate with teaching hospitals to reallocate positions in their GME programs. I believe that undergraduate and graduate medical education should be better coordinated and that this responsibility should be placed upon the Nation's medical schools. The medical schools already have substantial influence over the teaching hospitals by virtue of supplying graduate physicians to fill GME positions and by maintaining a degree of supervision and control over the clinical faculty teaching in GME programs. By requiring each teaching hospital that wishes to be eligible for Medicare funds for GME to have an affiliation agreement with a medical school, the school will be appropriately armed to negotiate with each institution to alter its GME programs. Similarly, this arrangement will provide an incentive for the school to take the leadership in seeking out new sites for primary care training to accommodate the additional students that will be required to enter primary care GME programs. I believe that it will be to the mutual benefit of the medical schools and the affiliated teaching hospitals to work in a cooperative manner to achieve the appropriate distribution of positions required by this proposal.

In summary, I believe that attention to these principles should allow us to develop a consensus around which a legislative proposal can take shape which will result in a more rational system of GME in this country. Although I have focused my comments on the manpower sensitive issues, I would like to add that I believe that a proposal based on these principles will result in cost savings for the Federal Government. First, it seems likely that the number of GME positions will decrease under such a proposal. Second, I believe that it is desirable to impose a cap on the stipend the Medicare will pay for each GME position. Finally, if appropriate attention is paid to the need to shift GME positions from non-primary care to primary care specialties, it should be possible to discontinue the Public Health Service grants which promote primary care training since they will no longer be needed for this purpose.●

Senator Dan Quayle

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FOR IMMEDIATE RELEASE
March 18, 1985

QUAYLE SCHEDULES MARCH 25 HEARING ON GRADUATE MEDICAL EDUCATION REFORM

WASHINGTON, D.C. -- U.S. Senator Dan Quayle (R-IN), chairman of the Senate Labor Subcommittee on Employment and Productivity, has announced that the panel will hold a hearing on March 25 on his recent proposal to reform the current system of graduate medical education (GME).

Under the proposal the Indiana Republican is developing, Medicare support for GME programs would be linked to teaching hospitals' compliance with national guidelines reflecting sensitivity to physician manpower issues. Quayle would require that a majority of the GME positions be allocated to primary health specialties and limit GME payments to facilities at which 75 percent of the trainees are graduates of medical schools approved by the Liaison Committee On Medical Education. In addition, Quayle's proposals would require teaching hospitals to affiliate with medical schools.

"Graduate medical education," Quayle explained in a January 31 Senate floor statement outlining his proposal, "is the generic term for the clinical training that interns and residents receive in the various specialties and subspecialties of medicine. This training is an integral and necessary component of the education of the physician in preparation for clinical practice.

"Graduate medical education is conducted in the Nation's teaching hospitals," Quayle continued. "GME programs vary in length depending upon the nature of the specialty training, but generally range between three years, for general internal medicine and pediatrics, and seven years, for thoracic surgery and other subspecialties.

"GME programs have always operated on the premise that the patient care and educational components of the clinical training experience are completely interwoven and thus all program costs should be accepted as a part of the cost of providing patient care," Quayle said. This principle was accepted at the time that the Medicare Program was established in 1965. For the past 20 years, Medicare has paid from the hospital insurance trust fund the costs associated with GME programs.

"However," Quayle noted, "during this time, third-party payers have exercised no influence over the number of training positions, the amount of the stipend associated with each position or the distribution of positions among the various medical specialties. At the present time, therefore, there is 'open-ended' funding for GME programs. Each hospital can determine if it wants to establish GME programs, the kind of specialty training it wants to offer and the number of positions to offer without any consideration of the costs involved.

"The impending insolvency of the Medicare hospital trust fund and concern with escalating health care costs in general have focused attention on the appropriateness of the educational costs incurred by the teaching hospitals," Quayle pointed out. "I believe that it would be inappropriate to divorce the funding of GME programs from the revenue that hospitals receive for providing patient care services. Accordingly, I believe that Medicare should continue to pay its fair share of the costs of appropriate graduate medical education programs. In my view, the issue then is not whether Medicare will continue to

(MORE)

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Page 2
pay GME costs, but whether Medicare will continue to pay in an 'open-ended' fashion regardless of the appropriateness of the GME system that exists in this country at the present time.

"While I believe that it is appropriate for the Medicare Program and, incidentally, other payers to continue to pay the cost of GME programs," Quayle said, "I believe that Medicare should pay only when it can be documented that institutions have responded in a responsible fashion to important societal issues regarding the number and specialty distribution of physicians."

Quayle said that he intends to develop the proposal he outlined in his January 31 Senate floor speech into specific legislation based on the testimony he receives at the March 25 hearing.

The March 25 hearing of the Senate Labor Subcommittee on Employment and Productivity will be held in SD-430, beginning at 9:30 a.m.

NOTE: Senator Quayle's statement on "Graduate Medical Education: A Proposal for Reform" appeared in the January 31, 1985 edition of The Congressional Record on pages S 963-965.

Senator QUAYLE. Before I turn to the witnesses, it is a great pleasure to welcome to this subcommittee Senator Simon, a former colleague in the House of Representatives, a neighbor from the great Midwest, the State of Illinois. I enjoyed serving with him in the House and look forward to his service not only in the Senate, which I am sure will be a fine addition, but particularly having service on this subcommittee. We will look for your input, and I know I will value it, and I look forward to a very good working relationship with you. Welcome to our subcommittee. If you have any comments at this time, please proceed.

Senator SIMON. Thank you, Mr. Chairman. It is a pleasure to serve with you once again, and I am particularly pleased to be on this subcommittee. This is an area where, frankly, I am not an expert, and I have a great deal to learn.

I guess I start off, then, not assuming the accuracy of some of the assumptions even that are made in your opening remarks about oversupply and excess supply. My instinct, with no direct knowledge, is that when you talk about a maldistribution within the profession, that that is in fact the case. But when we talk about an excess of supply of physicians, I think we have to ask whether this is from the perspective of the physicians or from the perspective of the patients. I have not seen the latest figures, but I saw a 1982 figure referred to the other day. Average physicians had an income of $104,000. That strikes me as reasonably adequate. I recognize that a lot of physicians do not make that much money. But I am concerned about areas that are underserved.

And I would like to enter into the record, Mr. Chairman this list from the Southern Illinois University School of Medicine which includes a list of communities where they are in need of everything from allergists to dermatologists. Not surprisingly, family practice is the big need.

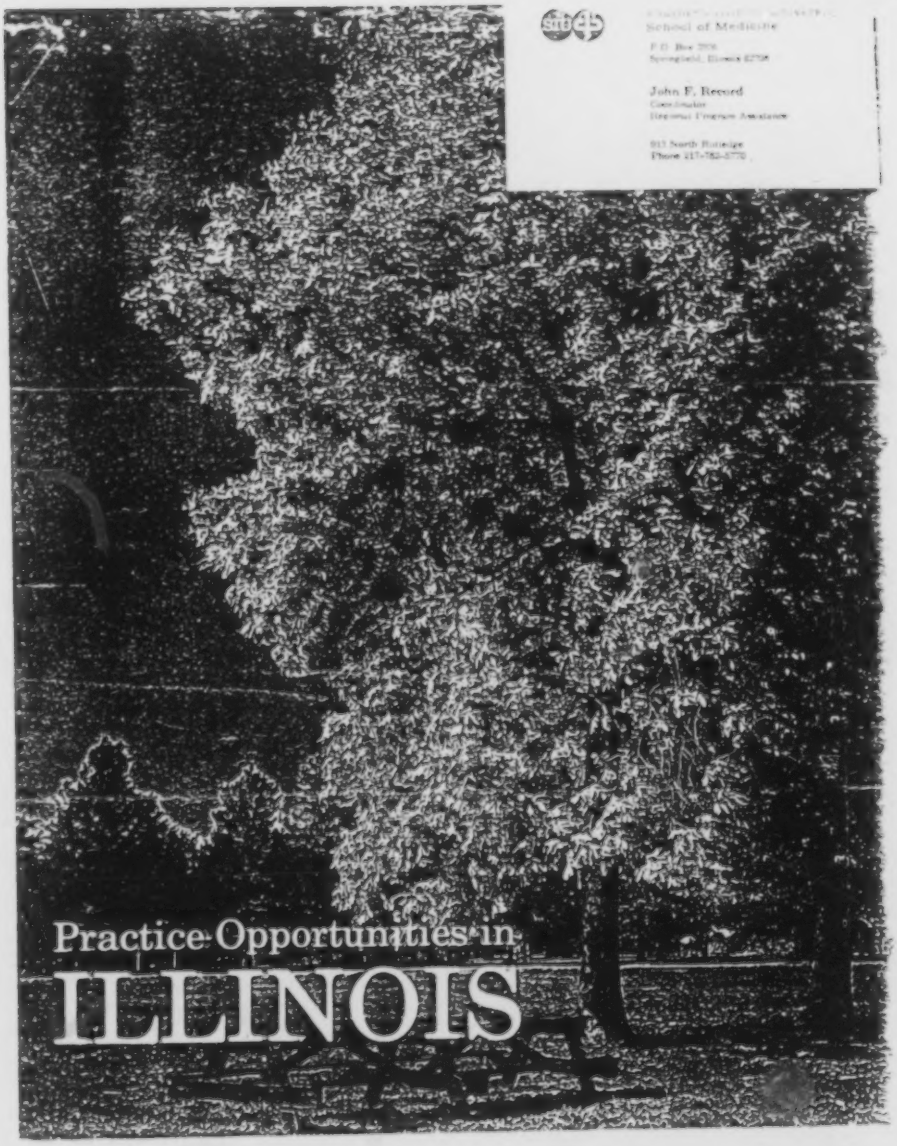
But I notice that communities like Carroll, IL, where I know there is a desperate need, are not even listed. They probably did not take the time to fill out the form that Southern Illinois Univer-

sity sent out. And I am sure there are other communities that fall in that category.

I am concerned that this Nation, which is No. 1 in medical research—and it should continue to be No. 1 in medical research—is not No. 1 in terms of infant mortality and a number of other bases that could be used. And as I look at inner city areas, and as I look at areas of rural poverty, I do not see any oversupply of physicians. Now maybe we can as we look at this whole area try and contribute to a better distribution not only within the professions, but within the country, to areas of great need.

So I am eager to learn. One of the advantages of not knowing too much is you can make quick, easy, sweeping conclusions, and I am ready to be rebutted and to be told my sweeping conclusions are wrong and to become more informed, and I hope to do that as a member of your subcommittee, Mr. Chairman.

[The list referred to by Senator Simon follows:]



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Senator QUAYLE. Thank you, Senator.

I might just say in brief response—and I think the question is on the supply of physicians. But actually, in this hearing, what we are going to try to establish today is the maldistribution between primary care and specialties. And that is really more of our focal point than the overall question of whether there is an excess amount of physicians or not.

Senator SIMON. I understand that.

Senator QUAYLE. I want to sort of break it down. It is fair game to ask that question and pursue that point, but my intent is to focus on what we have right now and the distribution between primary care and the subspecialties.

Before we proceed with the first witness we will receive for the record a statement by Senator Grassley.

[The prepared statement of Senator Grassley follows:]

March 25, 1985

Charles Grassley

CHARLES E. GRASSLEY

STATEMENT OF SENATOR CHARLES E. GRASSLEY BEFORE THE SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON THE TOPIC "GRADUATE MEDICAL EDUCATION"

THANK YOU, MR. CHAIRMAN. I WOULD LIKE TO BEGIN BY COMMENDING YOU ON THE CONTRIBUTION YOU ARE MAKING WITH THIS HEARING TO THE PUBLIC DEBATE ON A VERY IMPORTANT ISSUE.

THE ISSUE IN QUESTION, OF COURSE, IS HOW WE WILL PROVIDE SUPPORT FOR GRADUATE MEDICAL EDUCATION IN SUCH A WAY AS TO PROVIDE THE APPROPRIATE NUMBERS AND MIX OF MEDICAL PRACTITIONERS, WHILE AT THE SAME TIME PROTECTING THE ABILITY OF OUR TEACHING HOSPITALS TO CONTINUE TO MAKE AMERICAN GRADUATE MEDICAL EDUCATION THE BEST IN THE WORLD.

THERE DOES APPEAR TO BE A CONSENSUS TO THE EFFECT THAT WE ARE PRODUCING A SURPLUS OF MEDICAL PRACTITIONERS AND A MIX OF SPECIALISTS WHICH MAY NOT BEST MEET THE NEEDS OF OUR PEOPLE. THE HEALTH PROFESSIONS EDUCATION ASSISTANCE ACT OF 1976, DESIGNED TO HELP THE FEDERAL GOVERNMENT EXERT SOME DEGREE OF CONTROL OVER GROWTH AND COMPOSITION OF THE HEALTH PROFESSIONS, MAY HAVE HELPED TO PRODUCE ADDITIONAL PRACTITIONERS WHEN MORE WERE NEEDED, BUT IT DOES NOT APPEAR TO BE A GOOD VEHICLE FOR REDUCING SUPPLY, NOR HAS IT HELPED ARREST SPECIALTY MALDISTRIBUTION. THE FEELING HAS GROWN, THEREFORE, THAT WE SHOULD REOPEN THE ISSUE OF HOW BEST TO PROVIDE SUPPORT FOR GRADUATE MEDICAL EDUCATION.

WE ARE DISCUSSING THIS MATTER AT A TIME WHEN OUR HEALTH CARE SYSTEM IS EXPERIENCING VERY CONSIDERABLE CHANGE AS A CONSEQUENCE OF FEDERAL, STATE AND PRIVATE SECTOR COST CONTROL INITIATIVES. INDEED, IT IS PROBABLY NOT AN EXAGGERATION TO SAY THAT THE HEALTH CARE SYSTEM IS IN TURMOIL. IT IS LIABLE TO BE QUITE SOME TIME BEFORE THE PACE OF ALL THIS CHANGE SLOWS AND WE ACHIEVE A NEW EQUILIBRIUM. UNTIL WE REACH THAT POINT, ALL THE PARTICIPANTS IN THE SYSTEM WILL CONTINUE TO EXPERIENCE UNCERTAINTY AND CONSIDERABLE ANXIETY.

IT SEEMS TO ME, THEREFORE, THAT, AS WE DEBATE THESE ISSUES IN SEARCH OF AN APPROPRIATE PUBLIC POLICY, WE SHOULD REASSURE INTERESTED PARTIES ON A NUMBER OF POINTS:

FIRST, THAT WE IN THE CONGRESS RECOGNIZE THAT WE HAVE THE BEST SYSTEM OF HEALTH CARE, AND THE BEST METHOD OF TRAINING MEDICAL PRACTITIONERS, IN THE WORLD, AND WE WANT TO KEEP IT THAT WAY.

SECOND, THAT WE IN THE CONGRESS RECOGNIZE THAT THROUGH THEIR TEACHING OUR TEACHING HOSPITALS MAKE A CRITICAL CONTRIBUTION TO THE REST OF THE HEALTH CARE SYSTEM AND TO THE HEALTH AND WELL-BEING OF OUR PEOPLE, AND THAT THIS TEACHING DOES ENTAIL A COST.

THIRD, THAT THIS COST HAS TO BE REIMBURSED, AND, IN OUR EFFORT TO FIND THE APPROPRIATE METHOD FOR DOING SO WE WILL PROCEDE WITH CAUTION AND WITH REGARD FOR THE COMPLEXITY OF OUR TEACHING HOSPITALS AND THEIR RELATION TO THE REST OF OUR HEALTH CARE SYSTEM.

THAT IS ALL I HAVE FOR NOW, MR. CHAIRMAN. I AM LOOKING FORWARD TO HEARING THE TESTIMONY.

Senator QUAYLE. We will now proceed with our first panel of witnesses, Dr. Relman, Dr. Heyssel, and Dr. Daly.

We will begin with Dr. Arnold Relman, who is a professor of medicine at Harvard Medical School and editor of the New England Journal of Medicine.

Welcome, Dr. Relman. Please proceed.

STATEMENT OF DR. ARNOLD RELMAN, PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, AND EDITOR, THE NEW ENGLAND JOURNAL OF MEDICINE, BOSTON, MA.; DR. ROBERT M. HEYSSEL, PRESIDENT AND DIRECTOR, THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.; AND DR. WALTER J. DALY, DEAN, INDIANA UNIVERSITY SCHOOL OF MEDICINE, INDIANAPOLIS, IN

Dr. RELMAN. Thank you, Mr. Chairman, and thank you for inviting me here to give my opinions on this important subject. I will state my personal views and will not be speaking for any organization on institution with which I may be affiliated.

You have asked me to give my views on whether the Government should attempt to influence the Graduate Medical Education Program in this country, without spending too much attention on the details of the funding mechanisms, and that is what I intend to do.

I will be speaking from notes, Mr. Chairman, with your permission, but will provide your committee with a written copy of my comments within a few days.

Senator QUAYLE. OK.

Dr. RELMAN. Let me say at the outset that I believe the Government should attempt to influence the distribution of training slots in this country in graduate medical education, but in the least intrusive way, allowing the private sector maximum flexibility within broad guidelines set by Federal policy.

Now, my view that there is a need for regulation is predicated on several assumptions which I will outline very briefly, but which I believe can be supported by fact.

First of all, I think it is a fact that the total numbers and kinds of physicians in practice are a powerful influence on the cost and quality of medical care. This influence is not that predicted by classical market theory, because medical care is significantly different from a business, and physicians are significantly different from commercial suppliers of a service.

The consumers of medical services are critically dependent on the professional advice of physicians in a way that makes the practice of medicine different from the conduct of a business. Medical care is not quite the same as other essential commodities such as food, clothing, and shelter.

Therefore, I believe that we cannot and should not depend on free market forces to regulate the distribution of health care. A surplus of physicians, while it may ultimately and probably would reduce the income of physicians, will not lower the cost of health care. It will increase it. And it will lower the quality of health care, not improve it. If we have more specialists and less primary care physicians than we need—as I believe is now the case—we tend to

see more high-technology, expensive procedures than we require, and less attention to prudent, cost-effective practice. Specialists are trained to practice their specialty to the hilt and are not likely to think first of prevention or public health considerations.

I believe that in fact, we do now have as many physicians as we need, total, and certainly, more specialists than we need. And both of these problems will be increasingly severe in the future.

I appreciate the fact that many people in many parts of the country do not perceive a physician oversupply. Senator Simon spoke to the point that there are still many parts of the country where there are not enough doctors. That is true. But if you attempt to solve that problem simply by loading more doctors into the system, you have not solved the maldistribution problem. What is going to happen is that most of those doctors whom you load into the system are going to go where most of the doctors are now, for the same reasons that originally determined the distribution. And you will succeed in filling up the underserved areas only at the very high and, I think, undesirable cost of having an enormous surplus of physicians, particularly specialists, in most other parts of the country. The price will be very high.

Furthermore, the estimate of how many physicians we need has been made by the GMENAC committee based on the present health care system. If in fact we move more and more toward the HMO concept and have a high percentage of patients being taken care of in prepaid, organized systems where medical care is contracted for, the requirements for physicians and the requirements for specialists will even be lower than the present estimates, and the excess of specialists and of total physicians will be even higher.

So, to my way of thinking, there is no question that we are heading for, if we are not now there, an excess of physicians, and this is ultimately going to be bad for the country. Physicians have an enormous power to determine the utilization of health care services. It is not like classical market theory, where if you have too many suppliers, the price goes down, and people stop going into the market because they cannot make much money. The power of doctors to control the use of their own services and the use of other health services is so great that we will have a gross oversupply and a gross distortion of our health care system before market forces finally begin to make themselves felt.

I have no doubt that in the long run, the message will get back. If there simply is no room for doctors, if there is no opportunity for them to make a living or to work in the areas and in the specialties that they want, undoubtedly young people will stop going into medicine. But before that happens, damage will have been done to our health care system; the quality will fall, and the costs will go up.

Now, left to its own devices, I believe the private sector cannot and will not deal with this problem. It cannot because of the constraints of antitrust law, which now prevent organized medical groups from regulating entry for any reason other than quality control. The antitrust lawyers now tell medical organizations that it would be illegal for them to restrict the number of places simply for reasons of oversupply. And so it seems to me that, the capacity of the private sector to regulate itself in terms of numbers and dis-

tributional slots and so on, is very limited. Even if it could, it probably would not, anyway, because of innumerable conflicting vested interests and political pressures, at the local institutional level, at the State level, and so on, which put local institutional objectives above considerations of national policy. And everywhere you look in this vast heterogeneous and pluralistic society of ours, you see individual institutions, individual States, worrying quite understandably about their own special problems and being unable, for one reason or another, to take a broader view of what would be in the best interests of the country.

So, I believe, if we want to deal with this problem of oversupply and maldistribution, it is going to have to be done at the Federal level, where it will not conflict with antitrust law and where a national plan and a national policy can be developed.

Now, what should the principles of this national regulation be? I will only deal very briefly with principles and not with details. First of all, I believe very strongly that there should be Federal support only for graduates of LCME-approved U.S. Medical schools, plus a defined small number of alien graduates of approved foreign medical schools who would come here for training and then would return to their own country.

In other words, I think we ought to eliminate the opportunities for U.S. graduates of the offshore medical schools to come back into the system. This ought to be done prospectively, and with plenty of warning with "grandfathering" of those who are already in the system. But it does not make sense, it makes no sense at all for us to allow some 2,000 or 2,500 students of third rate medical schools, with inadequate education, to come back into the system if we believe the system is already being overloaded by U.S. graduates. If we really needed those doctors, we ought to give them proper training in U.S. schools.

Second, I believe that Senator Quayle's proposal of 70 percent of graduates going into the primary care specialties is reasonable. But I caution you—do not look at it from the point of view of entrance into training, but rather, exit, because there is a big shift in the distribution between entrance and exit. A goal of 30 percent specialists is reasonable by any standard, and I think that ought to be the objective.

How the specialty slots are allotted I think, ought to be up to some national body. Of course I am only talking about the places that are supported by Federal funds. There ought to be full opportunity for individual institutions to generate other training slots from their own sources.

I do not believe that the Constitution guarantees everyone a residency position in the specialty of his choice, and I think it would be foolish for the Congress to support the view that no American citizen, or no graduate of an American medical school ought to be denied a position in the specialty that he chooses to go into. It seems to me it ought to be competitive. The competition ought to be fair and equal, but it ought to be competitive, just as admission to medical school is competitive. We do not take the position that everybody is entitled to go to medical school, and I do not think we should take this position with regard to residency training.

As far as funding is concerned, I will not go into any detail. There are obviously many ways in which it might be done. I would simply conclude with this thought: We are only talking about Medicare's contribution to graduate medical education, which amounts to about 3 percent of what Medicare is now spending for health care. That 3 percent is very critical, however, because it influences how the other 97 percent is spent. Doctors have such a powerful and pervasive effect on how health care resources are being distributed and play such an important role in deciding how much money is going to be spent for health care that you have got to pay attention to that 3 percent. Therefore, you should not be too concerned about saving a few million, or even a few hundred million, in the funding of graduate medical education. Rather, you should be concerned about having the right kind of graduate medical education, so that when doctors go out into practice and exercise their professional influence over the major part of health care expenditures, they will be following policies and principles that are in the public interest.

One last point. Whatever you do, bear in mind that the teaching hospitals must survive and must remain viable. The teaching hospitals are the keystone. The teaching hospitals hold the whole structure of medical education and medical care in this country together. If you do anything that destabilizes the teaching hospitals, you undermine the whole structure at its foundation. So the needs of the teaching hospital must be kept in mind, whatever you do.

Thank you very much.

Senator QUAYLE. Thank you very much, Dr. Relman.

Our next witness is Dr. Robert Heyssel, president and director of the Johns Hopkins Hospital.

Dr. Heyssel, welcome.

Dr. HEYSSEL. Chairman Quayle, Senator Simon, thank you for asking me to be here today. I want to underline something that Dr. Relman just said, which is that in terms of total cost for graduate medical education, leaving aside the indirect cost issue for the moment, the numbers are relatively small, but they influence enormously what the physician manpower looks like. Second, Medicare's share in that is about a third, and whatever Medicare might choose to do, hopefully, the other payers will follow, because one of the things that is also true is that even if the Federal Government makes a decision to fund graduate medical education through Medicare trust funds or payment for patients one way or another, if the other third party payers do not, then the entire system is in trouble, including our teaching hospitals.

It seems to me the issues, then, are costs, and who pays for graduate medical education; the size and specialty mix distribution, which you have indicated great interest in, Senator Quayle; and finally, who controls graduate medical education and how and who makes the manpower decisions.

If I may refer to the chart. Attached to the testimony that I have given you previously is a chart which indicates the various players involved in graduate medical education today. The system that has grown up is not one that was drawn by design, but rather, by the interests of various groups over the year, the AMA, the specialty societies themselves, the specialty boards, and so forth. The chart

indicates that the Accreditation Council on Graduate Medical Education delegates its authority, after developing general essentials of graduate medical education, to residency review committees.

The ACGME, so-called, is a creature of the American Board of Medical Specialists, the AMA, the American Hospital Association, the Association of American Medical Colleges, and the Council on Medical Specialty Societies. I could go on through the chart, but I think the point I want to make is that, in fact, there is no single locus of control, and there are a lot of players with lots of interest. It underscores what Dr. Relman said, that the sort of voluntary control on specialty mix or size just simply is not there.

Further, support of graduate medical education primarily comes through the payments to teaching hospitals, some 85 percent of it—not to medical schools. So the suggestion that medical schools somehow could control the mix, size, specialty distribution and so forth, I do not think will work.

The issue, then, is how do we go about controlling that. And at that point, I would agree with Dr. Relman that there is no constitutional guarantee that everybody should be allowed to enter the specialty of their choice, particularly at general society expense.

As a consequence, there might be other proposals as to how we could limit the numbers going into the subspecialties because that really is the issue, is what people do after a basic 3 or 4 years of training—the entry into subspecialties out of internal medicine, pediatrics, and other specialties.

It is worth noting that in the past year, 63 percent of all graduates entered training in either internal medicine, family practice, pediatrics, or ob-gyn. The number who go on to subspecialize in other areas is, it seems to me, the issue, plus the numbers who enter the surgical specialties and subspecialties.

It seems to me in some manner to be determined, that there was a guarantee, there should be a guarantee of 3 years of funding for anyone coming from an LCME-accredited school, and some limited number of foreign trainees. After that time, the funding for further training could be based on either the institution's desire to support a subspecialty in a particular area, or professional fees, or other support—endowment funds, scholarships, et cetera—In effect, you would have the market forces, the desires of people to enter subspecialties, controlling the total numbers entering those areas.

You would reduce significantly the number of physicians supported by Medicare and other third-party payers. If the graduates of LCME-approved schools—some 15,000 at this moment—were given those 3-year guarantees, that would mean some 45,000 positions being supported, plus perhaps an additional number for certain specialties beyond that. But the total would be significantly reduced, at least in terms of the public payers.

I would point out that the payment mechanism is very broad based at this point, that it comes from Medicare, Medicaid, and most third-party payers who participate. So all would benefit from that sort of approach.

I have concerns with any approach that would have some sort of national commission setting the number of specialty slots, and would far prefer to guarantee the basic training and let the market in effect take care of apportioning the specialty slots thereafter.

I think, Senator Quayle, I would stop at this point.
Senator QUAYLE. Thank you very much, Dr. Heyssel.
[The prepared statement of Dr. Heyssel follows:]

Testimony

Robert M. Heyssel, M.D.
President
The Johns Hopkins Hospital

United States Senate

Committee on Labor and Human Resources

Subcommittee on Employment and Productivity

March 25, 1985

Senator Quayle and members of the Committee, I am Dr. Robert Heyssel, President of The Johns Hopkins Hospital in Baltimore, Maryland. I appreciate the opportunity to speak with you this morning about graduate medical education (GME). Senator Quayle, in his proposal to reform GME, has accurately described several problems that surround the way in which physicians are trained in this country.

First, let me address the problem of cost because I do not believe it to be the most crucial. Aggregate spending on GME has been variously estimated from $3 billion in direct costs to $9 billion total cost (both direct and indirect). Medicare's share of that cost is roughly 1/3. Measured against total annual spending for health care ($400 billion), GME represents a small percentage and the savings generated from Senator Quayle's proposal are not likely to significantly improve the fiscal position of the Medicare hospital trust fund.

However, concern with escalating costs in general have focused attention on the appropriateness of all medical care functions, including GME. The second two problems that Senator Quayle recognizes emphasize the appropriateness of the GME function, specifically the problems of size and specialty distribution. I agree whole-heartedly with the Senator that support for GME should not continue to produce physician manpower that does not match the medical needs of this country, in terms of both absolute numbers and specialty distribution.

To address these problems, the proposal has been made that a fixed percentage (70%) of residency positions at each institution be designated for the primary care specialties--internal medicine, pediatrics, family practice, and obstetrics/gynecology. The Association of American Medical Colleges (AAMC) has recently reported that for this current academic year, 63.6% of U.S. medical school graduates matched into these four programs. A fixed percentage, as proposed, would only regulate what is now occurring to a large extent.

The problem of specialty distribution actually begins three years after the medical school graduate chooses a primary care specialty - when, as examples, the internal medicine resident decides to pursue further training in endocrinology or gastroenterology; or when the pediatrician chooses to

specialize in pediatric cardiology or oncology. Open-ended financial support of graduate medical education provides no incentive for the graduating medical student to select shorter (less expensive) training programs. Instead of fixing a percentage of residency positions for primary care, the Committee might consider having Medicare fund graduate medical education for a finite period of training - either three years or to the point at which a resident becomes eligible for board certification in a general specialty area (ranges from three years in the primary care specialties to five years in the surgical specialties).

The rationale for advocating a level of support equal to the cost of three years' training is to establish a finite limit and to have that limit coincide with board eligibility in the primary care specialties. This kind of a limit might provide incentive for fewer internists to subspecialize in gastroenterology, for fewer pediatricians to pursue advanced training in pediatric cardiology, and as another example, for fewer doctors to enter the lengthy training programs in the surgical specialties. In effect, we would be funding generally accepted minimum competency in primary care specialties and allowing people and programs to make their own decisions concerning indebtedness or risk associated with going on into subspecialization. This form of market control, I believe, has a much better chance of yielding a proper mix of specialties than does setting

arbitrary numerical limits.

However, most important to the problems of cost, size, and specialty distribution is the problem of control.

(Refer to Chart)

I will try to simplify what is actually a complicated system of design and control for graduate medical education programs. The Accreditation Council on Graduate Medical Education (ACGME) establishes general requirements for GME programs and authorizes residency review committees (RRCs) to review and accredit individual programs in graduate medical education. Each residency program must conform to the set of general requirements and to special requirements established by the residency review committee for its specialty. These requirements generally concern faculty, administration, and program content. Each RRC also determines minimum program length ranging from three years in the so-called primary care specialties to seven years in thoracic surgery.

Independently, medical specialty boards establish the educational criteria that residents need to achieve to be considered for certification in a given specialty. The specialty board recognizes individual physicians (as opposed to residency programs) who have met requirements specified

by the board and who have successfully completed an accredited residency program. As you can see, the potential exists for a medical specialty board to require a longer period of training for board certification than a residency review committee would require for accreditation of a GME program.

The reason I bring this to your attention is not to confuse you. The fact is that the accreditation process for residency programs and the certification process for practicing physicians is carried out in isolation from the financing of graduate medical education. Payors for medical care, who support graduate medical education, have no clear voice in decisions that affect the design and content of GME programs - decisions that have ramifications for the cost of health care and for the financial status of teaching hospitals.

It has been proposed that each teaching hospital engaged in graduate medical education have an affiliation agreement with a college of medicine. I am not sure I understand exactly what will be accomplished by having medical schools distribute positions for graduate medical education. First, there are major GME programs not affiliated with colleges of medicine with first-rate academic programs. Second, most medical schools are not prepared to take on multiple affiliations with hospitals that have relatively few GME

programs and that are not closely affiliated with the school in terms of ownership, academic leadership, and geographic proximity.

Finally and most importantly, as noted in the chart, practically all funding for GME flows through teaching hospitals--not through medical schools. While it is true that some universities own hospitals and, in some instances, the operation of those hospitals is controlled by the medical school--there are many teaching hospitals where this is not the case. Because residents have both an educational experience and a service function that require balancing in the best interest of the trainee and the hospital alike, it is doubtful that medical schools are positioned to influence many, perhaps the majority of GME programs in terms of size and content.

GME positions can be distributed to graduates of medical schools more easily and more equitably through a system of vouchers. As Senator Quayle suggests, distribution can be limited to graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME). When such a system is applied with the three-year option described earlier, Medicare's financial responsbility is reduced to a level that provides funding for three years of graduate medical education for each medical student graduating from an American medical school. Using the number of students

who graduated from LCME-accredited medical schools in 1983 (15,885), the number of total positions receiving partial support through Medicare would be equal to three times the number of annual graduates or 47,655 positions. Currently there are some 76,000 residency positions, including roughly 7,800 funded through the Veterans Administration.

Let me underscore two important points made earlier for your consideration as you examine the future role of Medicare in the support of GME. I noted that Medicare supports approximately one-third of graduate medical education training--that one-third reflects the fact that over 80% of all funding for GME flows through hospitals and that Medicare pays for approximately one-third of all hospitalized patients. Since Medicare, Medicaid, and all other third party payers support GME, we have in effect, a very broad base of participation through an indirect tax or contribution from all payers. This system of funding is very vulnerabale to changes of payment policy or practice in the private sector as well. Mechanisms to assure their continued participation are paramount in any consideration of changes in funding or control of GME. The role of states in these decisions and arrangements is also important and merits careful evaluation.

Second, while graduate medical education is the term applied

to residents in training, the fact is residents render essential services in our hospitals. The point to be emphasized is if residents were not rendering these services, someone else would have to do so and, in some instances, probably at greater cost.

In summary and in conclusion, I agree with Senator Quayle that it is appropriate for the Medicare program and all other payers to support graduate medical education. However, that financial support should not be open-ended and some finite limit on the number of residency slots and/or years of residency training should be imposed. Control of the size and design of graduate medical education programs should remain in the private sector but formal linkages between accrediting bodies and those who pay for graduate medical education should be established. Finally, I have suggested an alternative mechanism to distribute funds for graduate medical education - a voucher system. A resident would receive a voucher to be used to purchase his or her medical education - limited to three years of support or first certification in a specialty area. Teaching hospitals could recruit residents carrying vouchers based on those specialties they felt they could adequately provide training in and for which they had received accreditation. Market demand would continue to determine the distribution of physicians across specialties, complemented by incentives for medical students to choose shorter training periods.

I appreciate your time and your attention.

Thank you.

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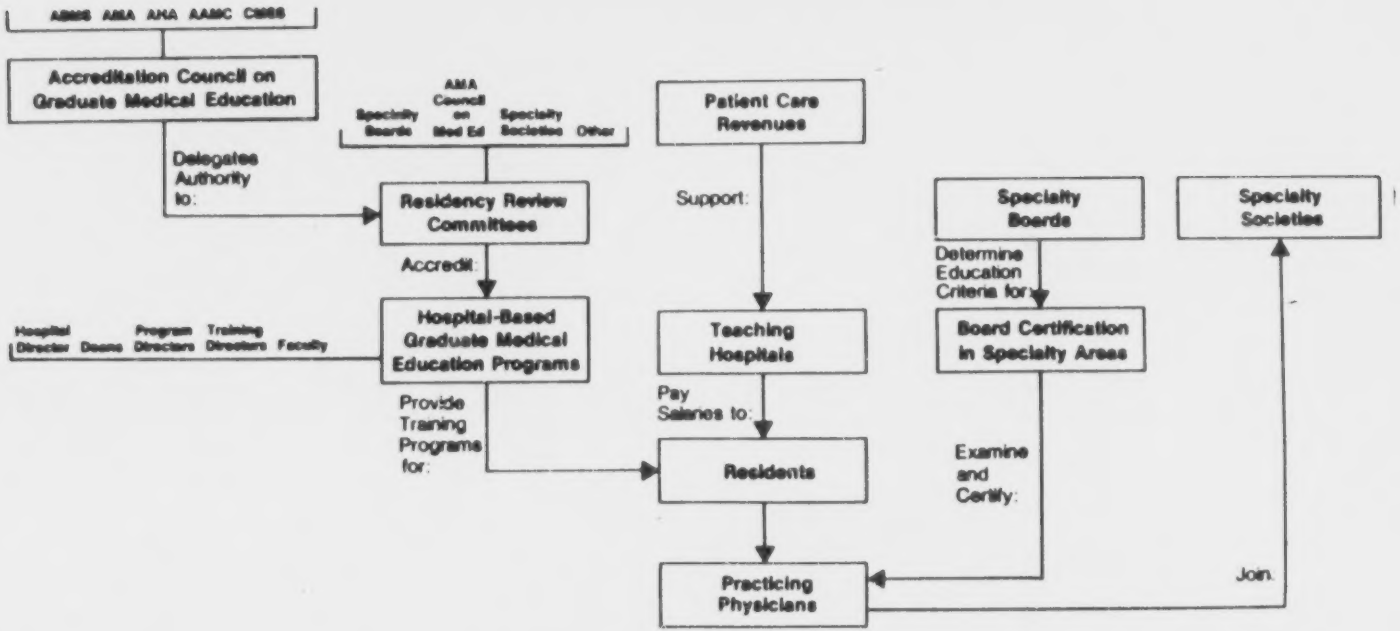
Control of Graduate Medical Education



Senator QUAYLE. The final witness, from the great Hoosier State, Indiana, the dean of the Indiana University School of Medicine, Walter Daly.

Welcome.

Dr. DALY. Senator Quayle, it is really an honor to come and tell you about Indiana. Senator Simon, it is a pleasure to be here.

I would like to state that I have virtually complete agreement with the statements which have already been made. There are a couple points I would like to amplify, however.

One has to do with the issue of oversupply of physicians and the uneven distribution of physicians—geographical distribution of physicians, which I think is a very important issue.

We hear much about the fact that there are too many or there will be too many physicians. We hear stories about underserved areas. In Indiana currently, we are in the lower quartile of the country in terms of active physicians, and the projected figures for the future would suggest that we will remain so, despite the fact that we currently have the second-largest medical school in the country—only one medical school in the State, however. Now, I think that that kind of distribution, one State to another, has to be taken into consideration when issues of too many physicians are discussed.

Second, within the State of Indiana, there are only three counties that now have a number of physicians which is above the national average as it is now. One is aberrant, because it is a northern county, Wells County, with a large specialty clinic there that draws from other areas; one is Vandenburg County—and frankly, I do not understand that one—and the other is Marion County, which is, of course, the capital; only three. The rest are far below the national average at the moment.

The next point I want to make concerns the specialty distribution of physicians, and the points that have been made with respect to the current inability to regulate the specialty distribution, the selections which medical students or residents make is, I think, quite correct.

And furthermore, I would like to point out that educators—and that is what I see myself as—cannot regulate distribution. We cannot determine that. Our role is to produce the best possible people and to educate them in a way which will help them to serve the people and to meet their own ambitions in the best possible way. We have no tools which provide us a mechanism for determining exactly what they will do. There is a difference between the role of the medical school, of the educator, in this field, and the valve which determines what field they will go into.

Furthermore, Dr. Relman pointed out that we are told that there are legal barriers, which prevent vigorous efforts at the control of the number of slots. And in other roles, other capacities, I serve on committees which accredit residency programs. And indeed, we are much concerned about the ability to regulate numbers, and we will—and there is evidence to show that we will—lose when appeals are put forth, particularly if the regulation has been done on the basis of control of specific numbers.

So I think that neither the hospitals nor the educators at the moment have the ability to regulate the number of specialists. I think someone else will have to.

Now, I would totally agree with Dr. Heyssel, I think it would be a potentially dangerous thing to create a national commission which determined exactly how many specialists of one kind or another there might be. Frankly, this would then become a body which was given powers which I think might be greater than the understanding and the data and the information available to deal with the problems, particularly concerning those which have to do with profound differences in geographic distributions.

A point has been made about teaching hospitals and their fragility, and I would like to underscore that. Although my primary role is as dean of a medical school, I am also director of the Indiana University Medical Center, which makes me responsible for a small cluster of teaching hospitals. We are very fragile these days, and we are fragile because we have to be price-competitive, and we have to be price-competitive without having the ability to be price competitive, because of our educational costs and because of the fact that we probably take care of more poor people than others. We certainly deal with more complex care than others. All of these factors may drive us out of the price-competitive world. If we were to suffer the loss of the sorts of educational reimbursements, both direct and indirect, this would be, I think, a considerable difficulty.

Now, Senator Quayle, with respect to your specific proposals, there were three points I would like to address. One has to do with a requirement for a medical school affiliation. Currently, in Indiana, we have 14 teaching hospitals, so defined because they have graduate programs. All of these have affiliations with the school of medicine at the moment. And information I have been given suggests that nationally, 80 to 90 percent of hospitals have such affiliations at the moment.

All of those hospitals in Indiana where we have such affiliations also share in our programs for the education of medical students. I believe this relationship has not been unwelcome in those hospitals and has not been a burden for them.

Now, with respect to the 70 percent issue with primary care, frankly, I do not know what the percentage should be. I do not know how one arrives at a specific percentage. In Indiana, currently about 62 percent are involved in the primary care disciplines. If one leaves out Indiana University hospitals, the figure is above 70 percent.

Now, this brings up the next point I want to make. Even if one does want to regulate the number of specialists, specialty training, and specialty education must continue; it cannot be abandoned. And if it is to continue, it will continue, as it is now, in certain of the teaching hospitals of the country. There are about 1,000 teaching hospitals in the country, but most residents are concentrated in about 100.

Those hospitals who are going to be engaged in producing the next generation of super-specialists—and we must have them—will have difficulty achieving a 70-percent primary care mix. I would think that such a figure would have to be spread over a broader base than individual hospitals, because some hospitals will have

difficulty doing that. And not only is it significant that they will have difficulty, it is more important that this problem will seriously impair the ability of the future to have the kinds of specialists that will be needed.

Now, with respect to the foreign medical graduate issue, I could not agree more with what has been said. Doing away with the heavy support of such positions would materially decrease the support now provided to the teaching hospitals for post-graduate education, and I think would be a considerable saving and entirely appropriate. In Indiana, the current figure is 4 percent; 4 percent of our residents are foreign medical graduates. The national figure is somewhere around 18 percent. Some States are 60 percent. And that unevenness of distribution, I think, is an important issue.

It seems to me that it would be to our benefit to have that figure reduced appreciably. Now, I would not want to suggest that it be done away with, because I think there are excellent individuals in many countries who should come to this country for postgraduate medical education and should return to the countries they came from, or should have some very special reason other than the usual ones now prevailing for staying here.

Now, I would like also to point out that I think we may be losing a considerable advantage if we totally closed the door to others from other countries, particularly those who are going back, because in many underdeveloped countries, these people will go someplace other than their country for their postgraduate medical education, and I think we might rather they come here than other alternatives which they might seek. When they go back, they will become the leaders in their country, and I think that is distinctly to our advantage. But I think the central issue in the whole foreign medical graduates problem is whether they return or not.

I really have no other comments to add, other than to thank you for inviting me to come and testify.

Senator QUAYLE. Thank you very much, Dr. Daly.

[The prepared statement of Dr. Daly follows:]

March 25, 1985
Walter J. Daly, Dean
Indiana University School of Medicine

Mr. Chairman and Members of the Subcommittee:

Thank you for asking me to present my views on a problem important to us all. I believe the nature of the solution to the problem of funding postgraduate medical education will condition the future of medicine in this country. It will be a factor determining the quality and number of future applicants to this country's medical schools; it will heavily influence the specialty distribution of physicians for the future, and it will influence the quality of preparation of tomorrow's doctors.

By way of introduction, I am Walter J. Daly, M.D. I am currently the Dean of Indiana University School of Medicine, the only school of medicine in Indiana. For thirteen years I was the director of a large and diverse internal medicine residency program -- diverse in that our people become primary care physicians as well as super-subspecialists.

As you are well aware, there is concern about the impact of postgraduate education costs on Medicare resources and on others who pay hospitals for the care they provide. The sums of money involved in this activity are indeed large, perhaps more than $2 billion annually. That is a staggering cost, but really it represents only a small fraction of total hospital expenditures, well within the range other industries might spend on their futures. This money is well spent. The system of postgraduate education in this country has become the most outstanding in the world. There was a time when our young physicians sought experience in Europe. Now the residency programs in this country are widely recognized for their excellence. The physicians who leave them are well prepared to provide the best medical care that science has made available to us; they are prepared

to adapt to new information as it comes along to change the accepted mode of practice; and they are brought up to be a vigorous advocate for each of their many patients.

Many years ago medical schools produced graduates who were expected to enter the practice of medicine directly. Now the educational programs of our schools produce young physicians who are expected to pursue a further rigorous program of education lasting three to seven years. These programs provide education and require service. Some have research components in their latter years. It is clear that these programs have real educational impact. Anyone who has compared recent medical school graduates and the finishing resident physicians can readily see a great difference. There has been growth in information and skills and above all maturity. The eager and often frightened medical school graduate has grown in confidence and learned to solve the problems in his own particular field of medicine. Yet throughout this period, the young physician has rendered service to patients and hospitals and worked hard in doing so. The real education these people experience centers around their involvement with a patient and a supervisor. In that setting, education and service is a mix which changes from moment to moment. Even when the supervisor is not present, the trainee knows he must soon answer for his actions, and his work is directed at achieving the standard expected of him in the next encounter.

Accountants seek to separate the cost of education and service in this setting. In reality such separations are artificial and should not be expected to reflect reality. At this level, education and service are inseparably intertwined. One cannot occur without the other. Education

does not take place unless service is being rendered and supervised service is really the essence of the educational experience.

Postgraduate education today is conducted in a large number of hospitals -- far more than the relatively few which are the property of universities. Today there is major concern that the costs of this educational activity now paid by Medicare and others will be withdrawn. If this should happen, many hospitals will cease to offer these opportunities or will reduce the number of positions. Some are already considering whether to remove these costs from their rate structures as they try to make themselves more price competitive. Yet it is commonly agreed that the teaching hospital offers more thorough and advanced care. The teaching hospital environment helps the teachers as well as the taught. The presence of students at all levels provides a more questioning atmosphere; such an atmosphere leads to a constant search for improvement. The hospitals which may withdraw from this activity will have chosen a quick financial fix at the long range risk of reduced quality of medical care. Furthermore just who is then to be responsible for educating the physicians of the future? Surely this is too important an issue to be decided on the basis of its impact on pricing as individual hospitals wrestle with their own increasing problems of price competition.

A few weeks ago I consulted at a small hospital in southern Indiana about this very problem. They have only a family medicine residency program and are thinking of abandoning it in response to the pressure of price competition. Hospital education programs of that sort are most vulnerable. Family medicine education, often best done in such hospitals, is particularly exposed and vulnerable. Yet the strength of

these programs and others which prepare young physicians to provide primary care is of vital importance.

Today our medical students are asking whether there will be postgraduate education programs available to them. They ask how they will support themselves during that time or whether they will have to pay tuition for further education after they graduate from medical school. The gestation period of the physician is long and already arduous without adding a further long period of indebtedness. After high school, our people spend eleven to fourteen years in further preparation. This year our Indiana medical students will have accumulated an average debt of $29,000 by the time of their graduation -- yet they will not be ready to pay it back for many years to come. They will be nearly thirty years old when they are ready for independent practice. In the absence of salary support during residency, the field will become unavailable except to the wealthy. High school students and college students right now are deciding whether to chance it in medicine or to choose other safer fields. Many of the best may choose careers other than medicine rather than invest such large portions of their lives in long preparation for uncertain and risky futures.

To summarize: It is clear that neither hospitals nor medical students can absorb the costs of postgraduate medical education. It is essential that these costs be supported and the proper sponsor is the user of hospital care. Not only does that person benefit from the environment in which education is conducted, but he benefits from the service provided. Society commonly uses similar support systems for programs it finds essential. Users support highways and public utilities. In the

private sector, purchasers of products support the industrial research required to develop the product they buy.

A few years ago it was dogma that there were too few physicians. Now it is becoming accepted that there will be too many. It follows then that the costs of postgraduate education are not a problem to be subsidized since the numbers ought to be forced down anyway. In reality no one knows how many physicians are needed. There are too many variables. What is clear however is that we must not sacrifice the slowly and painfully developed quality of our educational processes by precipitous action directed at manipulations of supply. Quality must be assured. Furthermore concern about overall numbers of physicians must not blunt our interest in specialty and geographic distribution. The unevenness of both is evident.

Senator Quayle has proposed that Medicare funds continue to support postgraduate medical education. But he has added a few requirements which must be met if this source of funding is to be available. In my judgment, the proposals form a good basis for further discussion. It is basic to the proposal that postgraduate costs should continue to be paid from patient care dollars. That is exactly where the programs should be funded since education is inseparable from patient care.

In order to qualify for that source of payment hospitals would then have to pass certain tests:

1. They must have a medical school affiliation. That is a reasonable requirement. In Indiana, all hospitals with residency programs have such an affiliation. Across the country, more than 90% of hospitals with residency programs already have a medical school affiliation. These affiliations do not permit the medical school to determine the nature or specialty distribution of residency programs

in other hospitals. In my judgment that would be an inappropriate intrusion into a problem best determined by each of these hospitals.

2. No hospital should have less than 75% of its residents as graduates of U.S. medical schools. In Indiana 4.2% of resident physicians are foreign graduates. Nationally only 18% are foreign graduates. Yet 17 hospitals in the country are unable to attract any U.S. graduates. In one state, 80% of resident physicians are foreign graduates. It is quite reasonable to address this problem. It would seem inappropriate to use patient care dollars or tax dollars to support such large educational programs for those who will return elsewhere or who have no continuity of experience with educational institutions of this country.

3. Seventy per cent (70%) or more of house officers in a hospital or in a network of affiliated hospitals should be in the primary care disciplines (family medicine, internal medicine, pediatrics, or obstetrics). It is difficult to determine why 70% is more desirable than some other figure, but an emphasis on primary care is entirely appropriate. However, this too is not an unattainable figure provided that percentages can be averaged over a base broader than a single hospital. While the proposal emphasizes primary care, it is also apparent that subspecialty educational programs must continue at some level and that those programs are best conducted in a somewhat restricted number of hospitals. Those hospitals then would have difficulty attaining a level of 70% primary care residents and should not be expected to do so. Yet as part of a broad network or an entire state, the 70% level could probably be attained. But it is reasonable to ask what the right fraction should

be. No one really knows, and those who might think they know would not agree. Seventy percent (70%) may be too high a fraction. It should probably be more than 50%. In Indiana, nearly 60% of resident physicians are now in the primary care disciplines and 72% of those residents in Indiana hospitals excluding Indiana University Hospital are in the primary care disciplines.

In my judgment, Senator Quayle's proposals are constructive and insightful. Funding postgraduate medical education is too important a problem to be allowed to float on the market in the absence of a source of adequate reimbursement for hospitals. Neither is it the sort of problem to be solved by heavy handed regulation.

As problems of postgraduate education funding are addressed, it must be recognized that the price competition now important to all hospitals makes these educational costs a potentially unwanted overhead. Unless these costs are appropriately reimbursed, it can be predicted that hospitals will withdraw from offering educational opportunities. Smaller community hospitals are most vulnerable; they provide mostly primary care residents; thus the primary care programs are at greatest risk.

Mr. Chairman, thank you for the opportunity to present these thoughts. This issue must receive careful consideration. The problem must be resolved in such a way that this important educational resource is preserved.

Senator QUAYLE. Let me just say at the outset here that my general proposition is to try to correct the maldistribution that we have between primary care and specialty.

I am in no way suggesting—as a matter of fact, I would oppose—government regulation, or a number to break down into specialty categories. I do not think we have the expertise. I think that it would be wrong. But I do believe, and what I am trying to pursue, is a general consensus or agreement about how many people we ought to as a goal have in the primary care field. And I have included ob-gyn in primary care for our discussion purposes on this.

Dr. Daly, you are absolutely right. Seventy percent, is that the right figure or not? I cannot say that that is ironclad, but I think as a general policy that that is reasonably close, and furthermore, there is probably going to be some sort of a waiver provision in extreme cases. Just take specialty hospitals, for example—I just want to exclude them from the outset. But as a general rule, what we are trying to do is to move and to correct this maldistribution that we presently have within the system.

Furthermore, I might say—and I agree with Dr. Daly's comment—that if we applied the 70 percent rule for primary care to each individual hospital on a case-by-case basis, that we would have some problems. What we are doing, and what we like to call it at least out here is the bubble concept—they do this in EPA, so we will do it in health care, too. The bubble concept is where you take the medical school and all the affiliates that it has and then apply that 70 percent or whatever the figure would come to. Because I recognize that if you have some teaching hospital that has a certain specialty, that you want to keep that, and you do not want to divert it just to try to make this 70 percent mark.

I have a couple of general questions. Dr. Daly, you said that having the requirement—or, not a requirement; right now, it is voluntary—an affiliation of the medical school with the hospitals is not a burden; that as a matter of fact, you found from your experience in Indiana that it is welcome.

Is that correct? The question I have, because I agree with the general principle that Dr. Relman talked about—just to lay out where I am coming from—I am trying to influence public policy in the least intrusive way as I possibly can, because I do not believe in a lot of regulation. I do not believe that a lot of controls are good. But I also do believe that there are certain standards and goals and precepts that we ought to try to achieve for reasons that are going to hopefully benefit society.

One of the things that we have talked about for our discussion purposes, if we are going to get a leverage on that policy decision, is an affiliation with the medical schools and the teaching hospitals. Some have said, well, it is voluntary now, and 80 to 90 percent, as you pointed out in your testimony, have it. But from your perspective, and I will ask the other two witnesses, do you think that this would be a burden to the hospitals? We are in no way saying that the medical school is going to get in and dictate to the hospitals on down the line what is going to happen, but we have to have some point of reference and focal point if we are really going to get some handle on the primary care situation.

I wonder if you might expand on your statement when you said that you did not consider it a burden?

Dr. DALY. Well, Senator, first of all, I must answer from the point of view of historical perspective. This has been going on for approximately 15 years and began at the time when our medical school began to have programs in a number of other cities and States. As part of the program to establish our educational system for medical students, this kind of an affiliation was produced.

And of course, whether it is a burden or not to a certain extent is in the eye of the beholder. From where I sit, it has not been a burden. And I have not had hospitals who are a part of our affiliation wanting system wanting to wrest themselves loose. Now, that may well be because we have not gone to them and told them how they were to conduct their business. It has sort of been an all-or-none phenomenon. They were part of our club, or they were not. We are affiliated, we do not intrude into the internal affairs of those hospitals.

Now, it seems to me that the greatest problem about this potential requirement for an affiliation is the guidelines which might flow with that. What does "an affiliation" mean?

One might say that my description of "an affiliation" is that it does not mean very much, and consequently, it has not been a burden. I can very well see that a fine hospital forced to have an affiliation with its medical school, might have a number of problems. This might be particularly difficult if there was competition for patients. If that affiliation meant that the medical school would have to tell them how to conduct their business within the usual scope of hospital affairs, there could be a considerable burden.

Furthermore, I would have to say that as the dean of a medical school, I do not have the internal bureaucracy to control such detailed affiliation with a large number of other hospitals. So on the one hand, you might say that our affiliations are so loose that they are meaningless, and on the other hand, if they were really tight, it could be a burden and could be quite a requirement for a school's bureaucracy to extend itself.

Senator QUAYLE. Dr. Heyssel?

Dr. HEYSSEL. Well, I would agree with that. In our own area, there are perhaps five or seven hospitals with teaching programs which I can think of which are not affiliated with either the University of Maryland or Johns Hopkins at this point. If an affiliation means, as Dr. Daly has said, that it is in title only, and we do not impose any of our own standards or requirements or anything else that we might do within our own institutions on those institutions, then in a sense, it becomes meaningless and a game in which we can count primary residents against our own perhaps different specialty mix.

If it means something different than that, with some standards and so forth being imposed through the medical school, then I think that both the hospital and the medical schools might have difficulties with that.

Again, to look back at the chart, the facts are that medical schools over time have not played the primary role in residency training programs. It has been the specialty societies and boards, setting standards; the various players accrediting programs; the

specialty societies examining and certifying physicians, and the money coming through the hospitals—with a good deal of service mixed in what is called education.

So I am not sure what is to be gained by having the medical schools do it, or if it is even functionally possible at the moment.

Senator QUAYLE. The model that we were contemplating is along the lines of the VA affiliation that we have. If you are famliar with that, that is a guideline. Would your answer then be the same, using that as a standard? Do you think that is going too far?

Dr. DALY. Well, Senator, in my capacity, I am also chairman of the dean's committee for an affiliated VA hospital. And that is, I think, a very valuable and warm relationship, and I think it has served both of us very well.

I would have to say that many hospitals who are not now affiliated would find that degree of affiliation burdensome. I think it is really not burdensome at that level, because the dean's committee really does not have control; it has a more advisory position. Now, if it has an advisory position, then perhaps it does not accomplish what you are trying to accomplish. I think that is the important difference.

Senator QUAYLE. What I am trying to accomplish is some focal point to get this policy decision implemented.

Dr. Relman, do you have any comment on this?

Dr. RELMAN. Well, just a very general one. This is one of several nettles that we are going to have to grasp. It is relatively easy to agree on many of the principles that we have discussed, and then you come down to the details of how are you going to do it. Some of us are unhappy with the idea of having a national committee assign the number of slots. But I personally believe that unless you do something like that, you are never going to achieve your objective.

I quite agree that to ask each individual hospital to achieve the mix that you want is unwise. It really will not work, and it should not be attempted. So, then, what is going to be the base? You suggest a medical school and its affiliated hospitals. Another base might be all the hospitals in the state. Or if you had a national committee, the base could be the country as a whole, and you will have to have some very tough negotiating and compromising.

This cannot satisfy everybody. There are going to be conflicts and there are going to have to be compromises. That is one of the reasons why it has not been done before—even before the Supreme Court said that we were a business and not a profession, and therefore, under the Sherman Act. It is a very difficult thing to do, but I would favor attempting it. Otherwise, I do not think it is going to be a meaningful program.

If you let the market decide how many and what kinds of specialty slots you are going to have, we will be back to where we were before.

Senator QUAYLE. Dr. Heyssel, I believe, in your prepared statement which I read, you talked about the possibility of pursuing a 3-year funding proposal. In other words, maybe we would fund for 3 years and then not—I believe that was the essence of your suggestion.

Would you view that as an alternative to what we are talking about now as a way to attain our objectives, and if so, could you maybe briefly compare the advantages of that particular process and what we have discussed and outlined here?

Dr. HEYSSEL. Three years, of course, coincides with the preparation for certification in internal medicine, family practice, and pediatrics. In Ob-Gyn, it happens to be 4. The other alternative on the same theme would be to first accreditation, which generally is at the end of 4 years. So a 4-year funding might be considered.

I think, for two reasons, it is an alternative. The first, is that it stops the open-ended funding which now gives no incentive for anyone to reduce training programs in general, except quietly and deliberately, as some specialty societies are alleged to have done to reduce numbers, because the payment is there within the hospital base, depending upon how many people anybody wants to train in a particular specialty.

It will shift some of the burden of decisionmaking to individuals who want to go on into specialty training, to the institutions themselves who desire to train people in a particular specialty, and bring some focus on the question of who should fund that, whether it is the general public that ought to fund somebody for a super-specialist job or whether there should be some risk for the individual and the institution in that decision.

Hopefully, people are going to look at the incentives a little bit differently. And if you then take the second thing that is happening, which Dr. Relman alluded to, the relatively rapid growth in this country of HMO's and other kinds of provider organizations, which have much less need for the super-specialists and much greater need for primary care specialists, if you take that and the fact that the hospital system in this country is shrinking and is likely to shrink more, thereby providing less opportunities for people who are in procedurally oriented specialties, I believe the combination of those two things has a very good chance of reducing or changing the mix considerably over the next few years—both in what areas physicians choose to practice medicine in—geographically, and in terms of their specialties.

The alternative to that is some sort of judgment of how many people we are going to need to do how many kinds of things in medical care, going forward. I do not think we have the ability to make those judgments in terms of what we know of the changing nature of medical practice and so forth over the next years.

So, yes, sir, I think it is an alternative.

Senator QUAYLE. There are a couple of things that concern me, but one is, if you abruptly terminate the pay at the end of 3 years, or extend it to 4 years, as you have talked about, then there is no Medicare funding for these specialty categories. And we have got a problem with the cost-shifting going on right now in the hospitals. And we are going to have specialties. Nobody is talking about doing away with specialties. We are going to continue that. And it would be a real heavy burden, I would think, to some of the hospitals or the private payers under that particular type of situation.

But I do think it is an alternative, and I might ask the other two to comment on that specific alternative, Dr. Relman and then Dr. Daly, and then I will yield to Senator Simon.

Dr. DALY. Senator Quayle, from my own perspective, the issue of funding the first 3 years and not funding others would have no impact on what we did, because we have had alternative funding for people beyond 3 years for a long time. The money has not come from hospital sources, at least for the direct cost. Indirect is a different issue.

Now, there is very little information nationally about how common that practice is. I do not know the answer to how common that practice is. But it may be that it is more common than is really known. But in Indiana, at our place, it has been that way for 25 to 30 years.

Senator QUAYLE. So you are basically saying from your experience that this would not have any impact on the shifting.

Dr. DALY. Correct.

Senator QUAYLE. Dr. Relman, do you have any general observations on this issue, on this alternative, looking at ways to approach it?

Dr. RELMAN. Yes; I think if one could get to where one wants to get by simply limiting the number of years of funding, that would be fine. I think, though, that you are not going to escape the need for some sort of national body to look at what is going on, to set limits, to make recommendations, to monitor the system.

I quite agree with my colleagues here that none of us—no committee, no group of physicians—has the wisdom to divine 5 years or 10 years ahead, or certainly 20 years ahead, exactly how many physicians we are going to need and of what kind. Things change too much. But that does not mean that you ought not to have some sort of body that is looking at the changing situation, making recommendations, making the best estimates that it can, and being prepared to change. You ought to be flexible, you ought to reassess the situation as often as possible. But I do not think we should throw up our hands and say no planning is possible.

Senator QUAYLE. Senator Simon.

Senator SIMON. Yes; thank you, Mr. Chairman.

First of all, Dr. Relman, your journal has a great reputation. I have to confess I am not a reader of your journal, but the New England Journal of Medicine is widely revered.

Dr. RELMAN. Thank you, Senator. I would be glad to see that you get a subscription, if you would like it. [Laughter.]

I do that for a number of your colleagues who have asked for them.

Senator SIMON. You just happen to have some blanks with you here.

First of all, if I could just talk on the last point you just made, this national body that you are talking about. Is this a quasi-governmental group? Is this the various AMA, AHA, and others there, authorized by law, so that we do not get into antitrust problems? How do we constitute this national body you are talking about?

Dr. RELMAN. Well, I would need some legal help at this point. I think that it ought to be—obviously, it has to be—authorized by law, or else we would get into antitrust problems. But its composition, I think, ought to be largely if not entirely in the private sector because that is where the action is and that is where the expertise is. And, to answer your question, such a group does not now

exist. We would have to set up a new body that would do this. And it ought to be empowered by law, but I think it ought to be largely in the private sector.

Senator SIMON. And as I understand the other two witnesses, you would not favor that?

Dr. HEYSSEL. No, sir.

Dr. DALY. I would not favor that, but also, I think that it might not even be necessary, if the current regulatory mechanisms were able to deal with the problem without being concerned with antitrust laws, because now, various specialty groups may for one reason or another—and I would presume they are oriented to the public good—would like to reduce the number of specialists of one kind. And they are unable to do so because of the various appeals processes which follow.

Dr. HEYSSEL. Senator, let me make another point. I think in attempting to set numbers, we have to remember that the numbers are driven somewhat by the number of medical school graduates. To put it another way, if the number of medical school graduates in this country is 15,000 or thereabouts, maybe more than that, then at least that many first-year positions, second-year and third-year positions, must be in the system, or we will not be doing what we need to do in terms of training manpower.

I would like to comment also to Senator Quayle's point, the question of cost-shifting between Medicare and the other payers. My presumption is hopefully that the other third-party payers will do what Medicare does, finally. The real worry is they may not. In a price-competitive system, they have the option of choosing hospitals which are not involved in graduate medical education, which could be a major problem for those of us who would provide it.

Senator SIMON. Since at least two of the witnesses have talked about this other problem that is really not the subject of the hearing today, but obviously, is related to it, and that is this oversupply—Dr. Relman, I have two questions. One is how do you define oversupply; and second, what do we do about the problem that Dr. Daly talked about in Indiana. And I do not have the entire State picture, but I could give you a great number of counties in Illinois where clearly, there is an undersupply including inner city areas where that is clearly the case.

Dr. RELMAN. Well, let me answer the last question first. I think that there ought to be economic incentives for medical graduates to go into underserved areas. I think it was a mistake to terminate the national health service corps.

In exchange for scholarships to medical school, students ought to be given the opportunity to serve in underserved areas. And then, I think, Senator Simon, we have to recognize that there are many ways of dealing with the problem of maldistribution. You do not have to always put doctors out there, as long as transportation is good, and you have got central clinic facilities that are within easy distance. There may be lots of parts of this country where it does not make any sense to have a physician practicing alone, or inadequately supplied, as long as patients can get to some sort of central clinic facility quickly and easily. But I think incentives to get doctors out there are the way to go.

How do I define "oversupply"——

Senator SIMON. If I may interrupt, just because you mention incentives, in fact, our incentives right now are in the opposite direction, aren't they?

Dr. RELMAN. Right.

Senator SIMON. Because you end up with $60,000, or $70,000 or $80,000 in indebtedness, and then you have a choice of going to Oakbrook, IL, a wealthy suburb, or Cairo, IL, a miserably poor community—and with that kind of indebtedness, you go not where society's needs are, but where your own pocketbook is.

Dr. RELMAN. Yes—unless you put a high value on fresh air and safe streets and good fishing and so on. But most graduate physicians go where most people go; they go where the symphony orchestras are and the resources are. So they are not going to go to rural areas, you are right. The incentives are in the opposite direction.

Now, so the other question about how one defines "oversupply" of health services. Well, obviously, one can't be very precise. I do not define it the way the economists do. If you start out with the economist's point of view, that health care is a business like any other, then oversupply is when the price starts to go down and providers no longer want to supply the product; that is, when supplying health care no longer looks economically attractive to physicians because of inadequate demand.

And the point I have tried to make, is that even an oversupply of doctors would have the capacity to generate enough demand to keep themselves busy, doing something. It might be by practicing what is being called "boutique medicine," which would not be good for the country. But doctors have the capacity to keep themselves busy, generating income for themselves one way or another, long after the usual laws of supply and demand would indicate that something ought to change.

Ultimately, there is no question that economic forces would play a role, and it would become less and less attractive for an oversupply of doctors. But as I say, there would be excessive cost and a serious decline in quality long before economic forces began to have their effect and the supply of physicians began to fall off significantly.

That is one of the big differences between health care and other kinds of commodities. Most commodities are distributed on the basis of wants, and the consumer's willingness to pay for what he wants. Health care depends on need, or it should depend on need, and it requires an advocate or an agent or a trustee whom the patient can trust, who represents the patient's interests with the patient's informed consent. That trustee is the doctor.

So, the best way to define how many doctors are enough is to ask what health care needs do doctors have to meet? Look at closed systems, for example, good closed systems, where all the health care is being provided to a defined population, and ask how many doctors do you need to take care of that population well. That will give you some idea. Even then, it is very inexact, and you have to be prepared to change your estimate almost year by year.

But I say, let's not throw up our hands and say we cannot plan because we really do not know exactly how many doctors we might

need. We really can plan, however imperfectly, and we really can estimate, however tentatively, the number of doctors we need.

Senator SIMON. Whoever wants to answer this—all three of you touched on the foreign medical graduate situation. You have two States where they are heavily reliant on foreign medical graduates—probably 50 States where to some extent, we are. But of the residency positions in New Jersey, 60 percent are filled by foreign medical graduates. If you were, Dr. Daly, to take these same counties that you listed and pull out foreign medical graduates, it would be a grim picture indeed in Indiana, if Indiana is like Illinois.

And where those Philippine doctors or Indian doctors are serving, frequently are the areas of great need that the graduates of Indiana University Medical School and the University of Illinois Medical School do not choose to serve.

What do you say for the New Jersey situation? What do you say to Norris City, IL, that is served because there is that foreign medical graduate there?

Dr. DALY. Well, first of all, I cannot answer that from experience. I have not had the experience. So I will answer it in how I think it might work.

First of all, I do not think it would be possible or proper—it would be possible, certainly, but not proper—to jerk away from those communities and those hospitals suddenly the access to the kind of foreign medical graduates who have been serving in those areas. I do not think that such a change ought to be made abruptly.

But I do think that once the process was started, and once the pressure was created by an increasing demand for residency positions for the graduates we currently have from U.S. schools, they would begin to find their way to those areas.

From the point of view of one who has been involved in the accreditation of residency programs, it is very difficult to determine that they are less satisfactory or less desirable or less worthwhile programs for postgraduate education than many others which commonly are filled with U.S. graduates. It becomes a matter of what the style is and what the track is. That is not a place where a U.S. graduate goes. Well, why not? It just isn't. And those are not rational reasons.

I think that those are the kinds of things which can be dealt with by the pressure of individuals seeking places, which is getting more intense. And I think that that can be counted upon.

If I may, I would like to go back to one of your earlier questions, having to do with geographical distribution, which I think is a very important one.

Medical students all across the country are finishing medical school these days with increasing debts. In Indiana, our students this spring will finish with an average debt of $26,000—and that is small, because we are a State school with low tuition.

It is my understanding that across the country, the scholarship programs which are made available by the military are well-subscribed. It is not because people like tbe military, it is because it provides a way for them to finance their medical education. It seems to me that that model can be used for recruiting people who want to go to many of these underserved areas.

The next point, with respect to these underserved areas, deals with the transportation issue, which Dr. Relman spoke to a moment ago.

In many circumstances, people want doctors in areas where they seek to go elsewhere for their other shopping. They will go 20 miles to buy a suit, but they think they should have the doctor across the street. And yet, transportation today is such that that is really not necessary.

Yet I would not deny that when whole counties are underserved, the issue is broader than transportation.

Another point is that as the teaching hospitals of the country are under duress and in jeopardy, and I believe they are—there are about 1,000 of them, but most of the graduate education is conducted in 100. What goes on in those other 900? I think that the distribution would show that those are primarily involved in the primary medicine disciplines. Family medicine is, very heavily weighted in those areas.

I have been visiting a number of hospitals in Indiana of those kinds that are now considering abandoning their post-graduate education programs because they are concerned about their hospital price competition. Were that to happen, there would be an even greater loss of the individuals who are most apt to go into the areas of practice that you are concerned about. And I think that those need to be very carefully protected, because they are the people who are going to serve in many of these more remote areas.

Senator SIMON. In addition, Mr. Chairman, Senator Kennedy, who is the ranking minority member on the full committee has a series of questions for two of these three witnesses and for others. If we can submit those questions to you for your answers, we would appreciate that, and Senator Kennedy, as you know, is very much interested in this whole health care field and has been one of the pioneers here, and we would appreciate your being willing to submit written answers to those questions for the record.

Senator QUAYLE. Yes. Chairman Hatch also has some questions that he would like to have submitted for the record. Of course, the health care issue is under full committee jurisdiction. This is a manpower issue that we are looking at from our subcommittee perspective. But both Senators would like to have the opportunity to submit questions. They have been very active in this area, and so they will.

Gentlemen, thank you very much.

[The following was received for the record:]

ORRIN G. HATCH, UTAH, CHAIRMAN
ROBERT T. STAFFORD, VERMONT
DAN QUAYLE, INDIANA
DON NICKLES, OKLAHOMA
PAULA HAWKINS, FLORIDA
STROM THURMOND, SOUTH CAROLINA
LOWELL P. WEICKER, JR., CONNECTICUT
MALCOLM WALLOP, WYOMING
CHARLES E. GRASSLEY, IOWA
EDWARD M. KENNEDY, MASSACHUSETTS
CLAIBORNE PELL, RHODE ISLAND
HOWARD M. METZENBAUM, OHIO
SPARK M. MATSUNAGA, HAWAII
CHRISTOPHER J. DODD, CONNECTICUT
PAUL SIMON, ILLINOIS
JOHN F. KERRY, MASSACHUSETTS

RONALD F. DOCKSAI, STAFF DIRECTOR
KATHRYN O'L. HIGGINS, MINORITY STAFF DIRECTOR

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510

May 2, 1985

Arnold Relman, M.D.
The New England Journal
of Medicine
10 Shattuck Street
Boston, Massachusetts 02115

Dear Dr. Relman:

Enclosed are some questions for you from Senator Hatch which were inadvertently left out when we mailed you your oral testimony for corrections. We apologize for this inconvenience and ask that you please answer the questions and return them to us as soon as possible in the enclosed envelope.

Again, we are sorry for the inconvenience. Thank you for your cooperation.

Sincerely yours,

Mary McGrane
Legislative Assistant to
Senator Dan Quayle

Enclosures
MM/kak

Questions from Senator Hatch: Dr. Relman

You have supported the notion of our nation's medical schools training 70% primary care specialists. How do you define this, given reports that most physicians in clinical practice, regardless of specialty classification, do a certain amount of primary medical care?

How can we best guarantee the "output" of 70% primary care physicians when residency programs to train this kind of doctor are not able to "pay their way" by generating sufficient funds from patient care?

You have expressed dissatisfaction with a termination of National Health Service Corps scholarships, a view I find difficult to understand. The purpose of the National Health Service Corps is, after all not financial aid, but to place primary care physicians in underserved areas, with the hope that they will stay for more than their required term. Selecting individuals for the NHSC when they are first year medical students, seven long years before service, seems to me to be less economically efficient, as well as less certain of success, than choosing individuals who are in the second and third year of their residencies. At that point in their career they are more aware of the type of practice and practice location they are interested in. While granting that some degree of loan repayment may need to exist as part of this approach, why is this not preferable to scholarships?

Answers to Questions from Senator Hatch

1) Concerning the requirement of 70% primary care specialists, I support the notion that our graduate medical education system should produce a net mix of 70% primary care physicians and 30% other specialists. By primary care physicians, I mean those who are trained to deal with the whole spectrum of everyday ambulatory medical problems, and who are prepared to follow patients over the long run and act as their primary medical adviser, referring them to other specialists as needed.

While it is true that many specialists do provide a certain amount of primary care (usually for the patients they are also following for a specialized problem), studies have shown that this type of care is usually quite limited in nature and that specialists are not able or willing to provide the whole range of medical services that patients need from a primary physician. Furthermore, this is an expensive and inefficient way to use specialists. If specialists provide primary as well as specialized care, we will have to produce far more specialists than are needed for specialized care alone. It is safer and more cost-effective to let specialists concentrate their attention on their specialty and let primary care physicians provide primary care. That is the way all efficient HMO's and closed panel systems do it.

2) The best way to guarantee an output of 70% primary care physicians is to continue the funding of graduate programs through third party payers (just the way airline passengers pay for the cost of training pilots and other specialized personnel) and to link that funding to the achievement of desired manpower goals.

3) Concerning National Health Service Corps Scholarships, I favor continuation of the program because I think it serves a useful dual purpose - financial aid and placement of primary care physicians in underserved areas. On the other hand, I agree with Senator Hatch that graduates who have already chosen primary care as their specialty might be better recruits. A program offering them assistance in setting up practice and repayment of educational loans might be very effective in getting them to go into underserved areas and stay there - particularly if there were some additional rewards for staying a certain number of years.

Arnold S. Relman

Dr. Arnold S. Relman

The Johns Hopkins Hospital

Robert M. Heyssel, M.D.
President

May 16, 1985

Mary McGrane
Legislative Assistant to
Senator Dan Quayle
United States Senate
Committee on Labor and Human Resources
Washington, D.C. 20510

Dear Ms. McGrane:

In response to your letter of May 2, 1985.

1) Q: Senator Kennedy - If vouchers were used to support the first three years of graduate medical training, what mechanism would you suggest to cover the cost of additional years of training? What impact would alternate mechanisms have on third party reimbursement costs?

A: Dr. Heyssel - I believe a variety of sources would emerge, ranging from institutional scholarships or stipends from endowment or other funds through the professional practice plans of medical school faculties and personal funds of individuals desiring training. The impact could be considerable on third party reimbursement since some 60% of all clinical fellows, primarily in internal medicine and pediatrics, are now supported by hospitals through third party reimbursement as well as all those physicians in surgery and other specialties whose boards require training beyond three years. An alternative is vouchers through first accreditation in a general specialty which, in general, would be no longer than four or five years. First accreditation would be in a primary specialty only so that it would not include the clinical fellowships referred to earlier.

2) Q: Senator Kennedy - How many teaching hospitals are affiliated with Johns Hopkins? Do you know what percentage of teaching hospitals in Maryland are affiliated with a university medical center?

A: Dr. Heyssel - Johns Hopkins has formal affiliations with six other hospitals for residency training, in three of which medical students receive a significant portion of

600 North Wolfe Street, Baltimore, Maryland 21205 (301) 955-5667

their experience, either on an elective basis or as part of a required rotation. I do not know what percentage of teaching hospitals in Maryland are affiliated with a university medical center, but affiliation does not really express the degree of involvement. I am sure most that train residents have, in one way or another, some ties to a university program; however, their residency programs in most instances are free-standing, i.e., not sanctioned by either Johns Hopkins or the University of Maryland. While the residents may rotate for brief periods of time to either of the two medical centers, and/or attend conferences there, the total educational program is the responsibility of the sponsoring hospital and not the responsibility of the universities.

11) Q: Senator Hatch - Why have our most prestigious, traditional medical schools resisted changing their curricula to encourage students to become family physicians, general internists, and pediatricians?

A: Dr. Heyssel - First, we need to distinquish between undergraduate medical education leading to the M.D. degree, and graduate medical education which prepares people for accreditation in the various specialties of medicine after granting the M.D. degree. The latter years are not under the control of the medical schools, and generally medical schools do not participate in the funding of those positions to any real degree. Basically, residency training programs are funded through the hospitals by payments for patient care to the hospital. This is not to say that many training programs in internal medicine and pediatrics, in "prestigious schools," have not emphasized specialty tracks as opposed to general training and greater experiences in ambulatory care, and that those schools have not, in general, developed programs in family medicine. While it is easy to say they have resisted change, the facts are the funding source for residency training is a powerful inhibitor to change. Since the payments come through the hospitals for hospital services, there is no source of support readily available for programs which move outside the hospital walls into ambulatory care training programs, etc., sites required for family practice training programs and general training programs in pediatrics and internal medicine. Most of the family practice programs started around the country have been started with general grants either from the Federal Government and foundations, or in some instances State sponsored schools and programs and, therefore, have had a different source of funding than most residency training programs. In my judgment, a change in the source of funding itself would be a powerful encouragement to change training programs.

2) Q: Senator Hatch - If payments for Medicare part A are limited to three years of training, should residents in the fourth year and beyond be allowed to bill directly under Medicare part B? If so, would there be any real shift in the incentives for training programs?

A: Dr. Heyssel - With regard to residents in the fourth year and beyond being allowed to bill Medicare part B if training programs were limited to three years of funding, that is a possible source of support for residency training beyond three years. Certainly, if that were allowed to occur, the incentives for a shift in training programs would be lessened. In general, I think that is the poorest alternative for supporting residents in programs beyond three years, or first accreditation of a primary specialty.

Sincerely,

Robert M. Heyssel, M.D.

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

OFFICE OF THE DEAN
Fesler Hall 302
1120 South Drive
Indiana University Medical Center
Indianapolis, Indiana 46223
(317) 264-8157

May 9, 1985

Employment and Productivity Subcommittee
SD-428 Senate Office Building
Washington DC 20510

Enclosed are questions directed to me following recent testimony before this committee.

Sincerely,

Walter J. Daly, M.D.
Dean

WJD:mjs

Encl.

from Dr. Kennedy

WALTER J. DALY, M.D.

DEAN, INDIANA UNIVERSITY SCHOOL OF MEDICINE

1) ARE GRADUATES OF THE UNIVERSITY OF INDIANA's TRAINING PROGRAMS FACING INCREASED COMPETITION AND OTHER PRESSURES RELATED TO PHYSICIAN OVERSUPPLY?

1. Those Indiana graduates who have completed their education in recent years have had to be more selective about the site they choose for their future work. Certain geographic areas and certain specialties are crowded. There remains ample opportunities for all of our graduates in almost all areas of Indiana.

Residency programs in the surgical subspecialties are becoming more difficult to acquire. Probably one out of three applicants can find places in the surgical disciplines of their choice. With that exception, there is ample opportunity for residency experience in the discipline they choose.

From Sen. Kennedy

WALTER J. DALY, M.D.
DEAN, INDIANA UNIVERSITY SCHOOL OF MEDICINE

1) DO YOU FEEL THAT INDIANA'S NEEDS FOR PRIMARY CARE PHYSICIANS IS ADEQUATELY MET? COULD YOU SAY SOMETHING ABOUT THE GEOGRAPHIC AND SPECIALTY DISTRIBUTION OF PRACTICING PHYSICIANS IN INDIANA?

2. Indiana's needs for primary care physicians are variably met depending upon the locality. In 1982. there were 207 physicians/100,000 population in the nation. In Indiana the figure was 143/100,000. Three counties were at or above the national average at that time. More recent figures have not been available to me. Numbers alone do not determine whether a region's needs for physicians are met. It is my suspicion that most areas of our state have an adequate physician supply though others could accommodate additions without difficulty.

QUESTIONS FROM SENATOR HATCH: Dr. Daly

You have pointed out that university hospitals are going to have to become more economically competitive. How are they going to support primary care residency training if the specialty training programs are able to generate more revenues for the hospitals?

In my judgment neither primary care nor specialty training programs really generate revenue for hospitals. Both are an expense. The current system of hospital reimbursement is tilted to favor cost containment so much that primary care physicians are really preferable because the patients they bring are less expensive.

My principal concern is that hospitals without a profound commitment to postgraduate education may withdraw from all such programs. It is unfortunately a fact that most such hospitals are more heavily involved in primary care residencies than subspecialty residencies. Of the thousand hospitals in the country having residency programs, half of the residents are in only 100 of them. Those other 900 hospitals are more heavily committed to primary care residencies.

In a relatively small community, a hospital without a residency program has a financial advantage over one with a residency program if the hospitals are to compete on a price basis. In the absence of support for postgraduate education from the payors of medical care, hard pushed hospitals will seek to maintain their price competiveness by whatever means available to them -- including withdrawing from postgraduate medical education.

Senator QUAYLE. The next panel is Dr. Murray Grant, Dr. Samuel Asper, and Dr. Alfred Gellhorn.

I am hopeful that our light system will be operative. Something went out with the first panel. But what we do, just as a reminder, is to try to confine our opening statements as much as possible, and when the green light is on, keep going; when the amber light comes on, that means you have about 30 seconds, and when the red light comes on, if you can finish your thought and conclude as soon as possible.

Dr. Grant?

STATEMENT OF DR. MURRAY GRANT, CHIEF MEDICAL ADVISER, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY STEVE SCHWARTZ, GAO; DR. SAMUEL P. ASPER, PRESIDENT, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, PHILADELPHIA, PA; AND DR. ALFRED GELLHORN, DIRECTOR OF MEDICAL AFFAIRS, NEW YORK STATE HEALTH DEPARTMENT, ALBANY, NY

Dr. GRANT. Thank you, Mr. Chairman.

I would like firstly to introduce my colleague to my left, Steve Schwartz, who was intimately involved in looking at the problem of U.S. students studying in foreign medical schools.

We are pleased to be here today to discuss our November 1980 report on U.S. citizens studying medicine abroad. In this report, we expressed concern about the quality of education provided to U.S. citizens by some foreign medical schools. We also pointed out the need for greater assurance that students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter graduate medical education or receive medical licensure in the United States.

Despite significant growth in the enrollment capacity of U.S. medical schools, many who apply are not accepted because of the intense competition for a limited number of positions. As a result, many U.S. citizens attend foreign medical schools with the goal of ultimately returning to the United States to practice medicine. The exact number of such citizens studying abroad is not known. However, we estimated that the number approximated between 10,000 and 11,000 at the time of our review.

Between July and November of 1979, we visited six foreign medical schools in the Caribbean, Mexico, and Europe which had about 5,400 U. S. citizens studying medicine. We met with school administrators and faculty, we looked at admission standards, curriculum content, and faculty credentials, and we observed facilities and equipment.

We also talked with many of the U.S. citizens about their experiences at the schools and their future plans. During these visits, we learned that many U.S. citizen foreign medical school students obtained part or all of their undergraduate clinical training in U.S. hospitals under arrangements made by either the hospitals, the schools, or the students themselves.

To get a better understanding of this training, we reviewed clinical training programs offered U.S. citizen foreign medical school

students at nine hospitals in three States—California, New York and Florida. The foreign medical schools we visited differed considerably, and the merits or problems of each must be viewed separately. However, in our opinion, at the time of our visit, none of these schools offered a medical education comparable to that available in the United States because of deficiencies in admission requirements, facilities and equipment, faculty, curriculum or clinical training. While it is difficult to generalize about the adequacy of the foreign medical schools in all of these areas, the inadequacy of the schools' clinical training represented the most serious shortcoming.

The type, length, and extent of undergraduate clinical training received by U.S.-citizen foreign medical school students at most U.S. hospitals we visited varied greatly, and generally was not comparable to that provided to U.S. medical school students. Most of the hospitals we visited were not affiliated with U.S. medical schools, and their training programs were inadequately monitored by the foreign medical schools.

Licensure for medical practice is a legal function of the 50 States, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. Although eligibility requirements differ among and within jurisdictions for U.S. and foreign medical school graduates, all applicants must submit evidence of their undergraduate medical education. We reported that State licensing boards have no way of adequately assessing the education and training provided in foreign medical schools in deciding whether a candidate for licensure had an adequate medical education and was eligible to take the State licensing exam.

Foreign medical schools do not receive direct Federal financial assistance. U.S. citizens attending these schools are eligible for guaranteed student loans from the Department of Education, and qualified veterans, their spouses, and their dependents may receive VA educational benefits.

Together, these agencies provided financial assistance to several thousand U.S. citizens studying medicine abroad, including many hundreds enrolled at four of the six foreign medical schools we visited in 1979.

Mr. Chairman, based on our work, we expressed the belief in our 1980 report that the proliferation of foreign medical schools established to attract U.S. citizens who are unable to gain admission to medical schools in this country was cause for concern.

We recognized that U.S. citizens were free to go abroad to study medicine and that many would continue to do so with the ultimate goal of returning to the United States to practice medicine.

Because at the time there were no adequate means of evaluating the education and training provided by foreign medical schools, we recommended that more appropriate mechanisms be developed to assure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before entering the U.S. health care delivery system for either graduate medical education or medical practice.

We are not in a position at this time to specifically comment on the actions taken to address all of the concerns discussed in our

1980 report. However, we are aware that a few States have taken actions in an effort to assess the quality of training received in some foreign medical schools, as well as their undergraduate clinical training in U.S. hospitals. We also are aware of the recent change which, beginning in July of last year, requires that all foreign-trained medical students seeking to receive graduate medical education or licensure in the United States take a different examination from that required at the time of our review.

Preliminary indications are that this new examination addresses some of the concerns we had with the previous examination.

At the request of the chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, we are conducting a study which will update some of the information jn our 1980 report. The study has two major objectives—firstly, to determine whether the problems we identified in our 1980 report are still present; and secondly, to identify those issues most in need of further attention.

We are meeting with Federal, State, and private organizations involved in physician examination, credentialling and monitoring to determine their current efforts to deal with the problems we identified in 1980. We expect to complete our study in July of this year.

Mr. Chairman, this concludes my statement, and we will be happy to try to answer any questions you or other members of the committee may have.

Senator QUAYLE. Thank you very much, Dr. Grant.

[The prepared statement of Dr. Grant follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m.
March 25, 1985

STATEMENT OF
MURRAY GRANT, MD, DPH
CHIEF MEDICAL ADVISOR
HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
UNITED STATES SENATE

ON

U.S. CITIZENS STUDYING MEDICINE ABROAD

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss our November 1980 report[1] on U.S. citizens studying medicine abroad. In this report, we expressed concern about the quality of education provided to U.S. citizens by some foreign medical schools. We also pointed out the need for greater assurance that students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before they are allowed to enter graduate medical education or receive medical licensure in the United States.

BACKGROUND

Despite significant growth in the enrollment capacity of U.S. medical schools, many who apply are not accepted because of the intense competition for a limited number of positions. As a result, many U.S. citizens attend foreign medical schools with the goal of ultimately returning to the United States to practice medicine. The exact number of U.S. citizens studying medicine abroad is not known. However, we estimated that the number approximated 10,000 to 11,000 at the time of our review.

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[1]Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal (HRD-81-32, Nov. 21, 1980).

In the past, U.S. citizens unable to gain admission to U.S. medical schools generally attended European schools. However, more recently, newly established schools in the Western Hemisphere, particularly in the Caribbean, have attracted increasing numbers of students.

WHAT WE DID

Between July and November 1979 we visited six foreign medical schools in the Caribbean, Mexico, and Europe which had about 5,400 U.S. citizens studying medicine. During our visits, we met with school administrators and faculty to obtain information on admission standards, curriculum content, and faculty credentials, and we observed facilities and equipment. We also talked with U.S. citizens about their experiences at the schools and their future plans. The schools we visited and their locations are listed in the attachment to this statement.

During out visits, we learned that many U.S. citizen foreign medical school students obtained part or all of their undergraduate clinical training in U.S. hospitals under arrangements made by either the schools or the students themselves. To get a better understanding of this training, we reviewed clinical training programs offered U.S. citizen foreign medical school students at nine hospitals in three states--California, New York, and Florida. We also met with officials of these states' medical licensing boards to determine whether they were aware of these programs. Additionally, we discussed with New

Jersey officials similar clinical training programs for foreign-trained U.S. citizens conducted in their state.

Before discussing what we found, I want to highlight several items that we should keep in mind. First, there are many first rate medical schools in other countries that produce excellent physicians. Second, many distinguished scholars from medical schools around the world are welcomed to this country as teachers and practitioners and make a valuable contribution. And third, even with limitations in a medical school's educational capabilities, some students will do well because of their own ability and willingness to study and learn.

I want to reemphasize that we visited only six foreign medical schools that were selected primarily because large numbers of U.S. citizens either had studied or were studying there.

WHAT WE FOUND

The foreign medical schools we visited differed considerably, and the merits or problems of each must be viewed separately. However, in our opinion, at the time of our visit none of these schools offered a medical education comparable to that available in the United States because of deficiencies in admission requirements, facilities and equipment, faculty, curriculum, or clinical training. While it is difficult to generalize about the adequacy of the foreign medical schools in all of these areas, the inadequacy of the schools' clinical training

represented the most serious shortcoming. When we visited the six foreign schools, none had access to the same range of clinical facilities and numbers and mixes of patients as a U.S. medical school.

Clinical Training
In U.S. Hospitals

The type, length, and extent of undergraduate clinical training received by U.S. citizen foreign medical school students at most U.S hospitals we visited varied greatly and generally was not comparable to that provided to U.S. medical school students. For example, at the time of our review, most of the hospitals we visited were not affiliated with U.S. medical schools, and their training programs were inadequately monitored by the foreign medical schools. Also, these hospitals had little assurance that U.S. citizens from foreign medical schools were adequately and properly prepared for clinical training.

Alternative Routes for Entering
the American Medical System

U.S. citizens we talked to who were studying at foreign medical schools said their goal was to return to the United States and practice medicine. Four routes are available:

--Transfer with advanced undergraduate standing to U.S. medical schools.

--Participate in the Fifth Pathway Program (1 year of clinical training in the United States under the supervision of a U.S. medical school).

--Enter graduate medical education in the United States.

--Obtain a license to practice medicine from a jurisdiction authorized to license physicians.

U.S. citizens at foreign medical schools who are unable to transfer with advanced standing to a U.S. medical school or participate in a Fifth Pathway Program usually enter the American medical system by participating in U.S. graduate medical education since it is also required for licensure in most states.

At the time of our review, U.S. citizen foreign medical school graduates had to pass the Educational Commission for Foreign Medical Graduates examination to enter graduate medical education. Less than 50 percent of the U.S. citizens taking this examination each year passed although the pass rate was reported higher for first-time takers than repeaters. Nevertheless, members of the medical profession had questioned whether this screening examination was adequate to serve the purposes for which it was being used--that is, as a test of the readiness for graduate medical education and as an adequate safeguard of the health and welfare of patients.

Licensure for medical practice is a legal function of the 50 states, Guam, Puerto Rico, the Virgin Islands, and the District of Columbia. Although eligibility requirements differ among and within jurisdictions for U.S. and foreign medical school graduates, all applicants must submit evidence of their undergraduate medical education. We reported that state

licensing boards had no way of adequately assessing the education and training provided in foreign medical schools in deciding whether a candidate for licensure had an adequate medical education and was eligible to take the state licensing examination.

Federal Financing Assistance for U.S. Citizens Studying Medicine Abroad

Foreign medical schools do not receive direct federal financial assistance. U.S. citizens attending these schools are eligible for guaranteed student loans from the Department of Education, and qualified veterans, their spouses, and their dependents may receive Veterans Administration educational benefits. Together, these agencies provided financial assistance to several thousand U.S. citizens studying medicine abroad, including hundreds enrolled at four of the six foreign medical schools we visited in 1979.

The Department of Education's records showed that during the 1970's, it guaranteed about 21,500 loans for over $45 million, and the Veterans Administration disbursed $5.6 million to 997 veterans, their spouses, and their dependents to attend foreign medical schools. Based upon Department of Education records, we estimated that the interest subsidies, defaults, and other expenses of the guaranteed loans had cost the federal government about $12.4 million during this period. We were unable to determine precisely the program's cost because the

Department's accounting system did not provide accurate and complete information on the number or amount of guaranteed student loans and defaults.

- - - -

Mr. Chairman, based on our work, we expressed the belief in our 1980 report that the proliferation of foreign medical schools established to attract U.S. citizens who are unable to gain admission to medical schools in this country was cause for concern.

We recognized that U.S. citizens were free to go abroad to study medicine and that many would continue to do so with the ultimate goal of returning to the United States to practice medicine. Because, at the time, there were no adequate means of evaluating the education and training provided by foreign medical schools, we recommended that more appropriate mechanisms be developed to assure that all students who attend foreign medical schools demonstrate that their medical knowledge and skills are comparable to those of their U.S.-trained counterparts before entering the U.S. health care delivery system for either graduate medical education or medical practice.

We also recommended that steps be taken to address the practice whereby U.S. citizen foreign medical school students received part or all of their undergraduate clinical training in U.S. hospitals because no organization had overall responsibility for reviewing and approving such training and there were no

assurances that the students were prepared to undertake such training.

We are not in a position at this time to specifically comment on the actions taken to address all the concerns discussed in our 1980 report. However, we are aware that a few states have taken actions in an effort to assess the quality of training received in some foreign medical schools as well as their undergraduate clinical training in U.S. hospitals. We also are aware of the recent change, which, beginning in July of last year, requires that all foreign-trained medical students seeking to receive graduate medical education or licensure in the United States take a different examination than that required at the time of our review. Preliminary indications are that this new examination addresses some of the concerns we had with the previous examinations.

At the request of the Chairman, Subcommittee on Health and Long Term Care, House Select Committee on Aging, we are conducting a study which will update some of the information in our 1980 report. The study has two major objectives

--to determine whether the problems we identified in our 1980 report are still as serious and

--to identify those issues most in need of further attention.

We are meeting with Federal, State, and private organizations involved in physician examination, credentialling and monitoring to determine their current efforts to deal with the problems we identified in 1980. We expect to complete our study in July 1985.

Mr. Chairman, this concludes my statement. We will be happy to answer any questions that you or other Members of the Subcommittee might have.

Attachment

Attachment

FOREIGN MEDICAL SCHOOLS VISITED BY GAO IN 1979

Caribbean:

Universidad Central del Este--in San Pedro de Macoris, Dominican Republic

Universidad Nordestana--in San Francisco de Macoris, Dominican Republic

St. George's University School of Medicine--in Grenada, West Indies

Mexico:

Universidad Autonoma De Guadalajara--in Guadalajara, Mexico

Europe:

Universita Degli Studi Di Bologna--in Bologna, Italy

Universite de Bordeaux, II--in Bordeaux, France

Senator QUAYLE. Dr. Samuel Asper, who is president, Educational Commission for Foreign Medical Graduates.

Dr. Asper?

Dr. ASPER. Mr. Chairman, Senator Simon, thank you very much for this privilege.

The Educational Commission for Foreign Medical Graduates is the gatekeeper to clinical graduate study in U.S. medical centers for graduates of foreign medical schools. Our responsibility is to examine and certify those FMG's who seek training here, using standards generally applied to graduates of our schools. ECFMG examines individuals. We do not examine foreign medical schools.

The influx of FMG's is well known. In 1983, of 519,545 licensed physicians in the United States, 112,005 were FMG's. Of these, 80,044 were aliens, most of whom have now acquired permanent residency status or citizenship. Most work in rural or densely populated, poor metropolitan areas, unattractive to our own graduates, and thus meet the needs of the underserved. Others occupy academic positions. Sixteen percent of our full-time medical school faculties today are FMG's.

In contrast, U.S.-citizen FMG's, whose numbers are increasing sharply, appear to follow practice patterns of our own graduates, and few of them hold academic posts.

I shall make four brief points. First, to correct certain inequalities, ECFMG in 1984 replaced its former two separate tests that Dr. Grant just referred to with the foreign medical graduate examination in the medical sciences. Called FMGEMS, the new examination is administered to both alien and U.S.-citizen FMG's, and is deemed by the Secretary of Health and Human Services to be the equivalent, for purposes of the law, to the examination given students in most United States and Canadian medical schools. It has now been administered twice, and although it is too early to compare the results of FMGEMS, as we call it, to those of the former ECFMG examination and the visa qualifying examination, it is my belief that the preparation and education in clinical medicine of some U.S.-citizen FMG's is woefully weak.

Second, despite current, strict limiting regulations on the immigration of alien physicians, and fewer opportunities for residency training of both alien and American FMG's, large numbers of them apply for ECFMG examination and certification. Although each year several thousand apply, few are successful. In 1983 and again in 1984, about 2,400 alien and 2,450 U.S. citizen FMG's obtained or were eligible to obtain ECFMG certification. That is the pool of qualified FMG's hoping to obtain residencies.

Third, despite widespread concerns, voiced by many, on the apparent poor quality of medical education in some proprietary medical schools abroad that cater to Americans, the number of U.S. citizen FMG's from these schools who apply and successfully obtain ECFMG certification is increasing annually. The sum equals the output of 20 American medical schools. Also surprising is the fact that, as compared to alien FMG's, the U.S. citizen FMG's appear increasingly successful in obtaining residency positions.

Fourth and finally, current immigration regulations concerning alien FMG's should benefit health care and medical education in other countries without adding to the sum of practicing physicians

in the United States. Unfortunately, however, most alien physicians obtain only those positions considered undesirable by our own graduates. They are denied the best scholastic opportunities. If the United States is to manifest leadership in international medicine and make good use of our superb faculties and facilities, the very well-qualified alien physicians should be in centers of high caliber. Such programs could be supported, I believe, from other than the usual funding sources.

Thank you.

Senator QUAYLE. Thank you, Dr. Asper.

[The prepared statement of Dr. Asper follows:]

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
COMMITTEE ON LABOR AND HUMAN RESOURCES

Room 430, Senate Dirksen Office Building

Testimony of Samuel P. Asper, M.D.

(Background Document)

President, Educational Commission for Foreign Medical Graduates
and
Professor of Medicine, The Johns Hopkins University School of Medicine

March 25, 1985

I am Samuel P. Asper, President of the Educational Commission for Foreign Medical Graduates. A physician and graduate of The Johns Hopkins University School of Medicine, I have long been engaged in international medical education. As associate dean at Johns Hopkins, I had the responsibility, along with other duties, for the international program in which annually there were 300 to 400 alien foreign medical graduates enrolled in fellowships in various specialties of medicine. I also directed the Commonwealth Fund-supported exchange program with three foreign medical schools, the University of Ibadan in Nigeria, the Cayetano Heredia in Lima, Peru, and the American University of Beirut in Lebanon. In 1973, I became dean of the medical school and chief of staff of the hospital at the American University of Beirut, a position I held until mid-1978. My position at ECFMG began in June, 1982.

The data I present today come from ECFMG and other identified sources. Any opinions offered are personal.

HISTORICAL ASPECTS OF ECFMG

The Educational Commission for Foreign Medical Graduates has been in existence for twenty seven years, brought about by the need to evaluate the credentials and assess the qualifications of the increasing numbers of foreign medical graduates who annually sought education and training in hospitals and medical centers in the United States. ECFMG certification is required of all foreign medical graduates, both aliens and U.S. citizens, seeking graduate medical education in U.S. hospitals. Since such clinical experience involves the care, under supervision, of patients, ECFMG has a public and professional responsibility to ascertain that foreign-educated physicians are qualified to enter such training. Today, ECFMG has seven sponsoring organizations: The American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Association for Hospital Medical Education, the Federation of State Medical Boards, and the National Medical Association. Each organization appoints two trustees to the ECFMG Board of Trustees, and there are six additional elected trustees, representing the public-at-large. ECFMG is a non-profit, self-supporting organization that derives its income solely from examination fees charged to applicants.

It should be recalled that following World War II there was rapid expansion of health care facilities as well as research in the United States. Physicians were needed. In the 1950's, 60's and early 70's, the U.S. gave immigration preference to well-qualified, ECFMG-certified foreign physicians. The number annually licensed to practice increased steadily until, in the mid-1970's, almost as many foreign medical graduates were licensed as graduates of medical schools in the United States.

In 1976 the Congress, in passing PL 94-484, declared that a shortage of physicians no longer existed and called for regulations that would limit the period alien foreign medical graduates who seek clinical training in graduate medical education could remain in the United

States. This public law, now slightly modified, requires that foreign governments or medical institutions certify that the training sought by applicants will be of benefit and that a position will be available for the physician upon his or her return to the home country. Moreover, the period of training in the United States is limited to that required in specific specialties, e.g., three years in internal medicine, five years in general surgery, and seven years in neurosurgery, the maximum time permitted. Further, those who obtain visas for study must, of course, be ECFMG-certified and must have an offer of a position from the director of an accredited training program. The introduction of PL 94-484 and its subsequent modifications has, in recent years, reduced considerably the number of alien foreign medical graduates entering residency training posts (vide infra) in the United States.

Beginning in the late 1950's, American citizens began to go abroad to study medicine, mostly to Europe, especially Italy. Competition for entry into a U.S. medical school was keen, with only one in four applicants gaining admission. Since the late 1960's, many Americans have gone to Mexico to study medicine, and, in the past ten years, to the numerous, newly-opened proprietary medical schools on the Caribbean Islands that cater to Americans. All this has occurred despite the fact that entry into a U.S. medical school is now gained by one of every two applicants.

ECFMG also is responsible for determining that U.S. citizen-graduates from schools abroad meet the minimum standard for entry into graduate education. The number of U.S. citizen-foreign medical graduates annually applying for examination and certification is increasing steadily (vide infra).

It is job opportunity and economic security that have led to immigration of alien physicians and the return of U.S. citizen-graduates of foreign medical schools. In 1983, the American Medical Association Division of Survey and Data Resources reported that of 519,444 licensed physicians in the United States, 111,161 (21.4%) were foreign medical graduates. Of the foreign medical graduates, 72% are aliens or former aliens, and 28% are U.S. citizen-graduates.

ECFMG EXAMINATIONS AND POLICY

In the public interest and safety, it is the responsibility of ECFMG to determine that foreign medical graduates who seek clinical experience here, such as residency or fellowship, meet the minimum standard set for graduates of U.S. medical schools. In addition to confirming that applicants for certification are bona fide graduates of medical schools listed in the World Directory of Medical Schools, published by the World Health Organization, ECFMG administers an examination in both medical science and English that applicants must pass.

From its inception and through February 1984, the Commission administered the ECFMG examination. Beginning in 1977 and through September, 1983, the Commission also administered the Visa Qualifying Examination. Beginning in July, 1984, both of these examinations were

replaced by the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). A description of these examinations and an explanation for the change follows.

The ECFMG medical science examination was a one-day written examination initially containing 360 questions and later 420 questions. Test items were selected from the bank of questions owned by the National Board of Medical Examiners, and they had been pretested on a standard reference group of students in U.S. medical schools who were taking the examination for NBME certification. It should be noted that the National Board of Medical Examiners administers its test to students in U.S. medical schools, and many schools require a passing grade on this test for graduation. The ECFMG examination was administered twice yearly for both foreign national and U.S. citizen-foreign medical graduates.

In 1977, in response to PL 94-484, ECFMG, in cooperation with the National Board of Medical Examiners, introduced the Visa Qualifying Examination (VQE), required of all alien physicians to obtain a visa for clinical training in the United States. This examination was a two-day examination, with 500 questions in the basic medical sciences on the first day and 450 questions in the clinical sciences on the second day. All questions were taken from the National Board of Medical Examiners' bank of examination questions. Applicants were required to pass both parts of the examination. Failing one part, they could be re-examined in that part again later. The examination was offered once yearly and was deemed by the Secretary of the Department of Health and Human Services to be the equivalent of Parts I and II of the National Board of Medical Examiners for purposes of the law.

The English examination tested knowledge of grammar and vocabulary, as well as auditory comprehension. A passing score was required for certification.

Despite the similarity of test items in the ECFMG examination and the Visa Qualifying Examination, the two-examination system was considered unsatisfactory, inappropriate and discriminatory between U.S. and alien foreign medical graduates. In the two-test system, U.S. citizen-foreign medical graduates took the ECFMG examination, whereas alien foreign medical graduates who were allowed to take the ECFMG examination and become ECFMG certified could only enter the United States if they also successfully passed the Visa Qualifying Examination.

Accordingly, in 1982, in affiliation with the National Board of Medical Examiners, ECFMG began the development of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Since July 1984, this new test has been administered to all applicants for ECFMG certification, both aliens and U.S. citizens. Approved by the Secretary of the Department of Health and Human Services, FMGEMS is divided into a one-day basic medical science examination and a one-day clinical science examination. An English test is also included. The test and its administration are patterned after the National Board of Medical Examiners. Students in most U.S. and Canadian medical schools can take Day One after they have completed their courses in the basic sciences

and Day Two just prior to graduation from medical school. Thus, those successfully passing both parts of the test can apply for graduate training at the same point in their education as U.S. medical students. FMGEMS is fair and equitable, and it has been adjudged by the Department of Health and Human Services to be the legal equivalent of the National Board of Medical Examiners test, our U.S. standard.

DATA ON THE ECFMG EXAMINATION, THE VISA QUALIFYING EXAMINATION, AND THE FOREIGN MEDICAL GRADUATE EXAMINATION IN THE MEDICAL SCIENCES

Although ECFMG has data on all applicants since its founding, only recent data will be given here to show trends. Again, it is important to note that both the ECFMG and the Visa Qualifying Examination have been replaced by the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Moreover, FMGEMS has been given only twice, in July 1984 and January 1985, and interpretation of the data and comparison to the former tests must be made with caution.

Table 1 provides data on ECFMG examinations. It shows a steady annual increase in the number of U.S. citizens applying for examination as well as the number achieving a passing grade. Note that approximately one third of Americans passed ECFMG, whereas less than one quarter of the aliens passed.

The question arises as to why so many alien physicians took the ECFMG, as it was also necessary for them to pass the Visa Qualifying Examination to obtain a visa. The answer probably is that the alien physicians took the ECFMG first as a trial. The cost of the ECFMG is approximately one half that of the Visa Qualifying Examination. If they were successful in passing the ECFMG, then they recognized that they had a reasonably good chance of passing the Visa Qualifying Examination. As mentioned earlier, however, some took the ECFMG simply to demonstrate that they had attained a U.S. standard.

Table 2 provides data on the performance of foreign national physicians on the Visa Qualifying Examination. Not shown in the table are data on the performance of examinees on the separate components of the examination. Slightly less than one half of the alien physicians passed the clinical science portion of the examination, whereas only about 20 percent passed the basic science portion. These data suggest that the curriculum in the basic medical sciences in some foreign medical schools is not as strong as it is in U.S. medical schools.

Table 3 presents data on the performance of medical students and/or graduate physicians on the new Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), with comparisons of the performance of foreign national physicians and U.S. citizens.

Other ECFMG data are reported by Dr. Ray L. Casterline, ECFMG Vice President, in his letter of March 6, 1985 to Dr. Michael Whitcomb (see Appendix 1).

In 1984, there were 18,457 first-year residency posts (formerly called internships) in accredited training programs offered under the

National Resident Matching Program (NRMP). Of these, 13,588 (74%) went to graduates of U.S. medical schools and 1,674 (9%) went to foreign medical graduates[1]. Of the latter, 922 (55%) were alien physicians and 752 (45%) were American citizen graduates.

DISCUSSION

In his letter of invitation, Senator Quayle asked for "a perspective on the size of the pool of foreign medical graduates who may wish to enter graduate medical education programs in this country." A precise determination of the number who wish to enter is difficult, as one half of the applicants for examination are repeaters, having failed one or more previous examinations. Some aliens applying for examination have no intent to study here, others are only curious to take an American test, and still others consider the test an educational exercise. In other words, the number of applicants for examination does not reflect accurately the number who desire graduate medical education here.

Senator Quayle's question is best answered by looking at the number of alien and U.S. citizen applicants from foreign medical schools who are qualified to enter graduate medical education and who apply for residency posts.

In round figures, in 1983 2,400 alien foreign medical graduates and 2,450 U.S. citizen graduates of foreign medical schools obtained or were eligible to obtain ECFMG certification. Thus, in 1983, 4,850 foreign medical graduates were qualified to enter, and it can, I believe, be reasonably assumed that most of them wished to enter.

In 1985, also in round figures, 7,000 alien and 3,000 U.S. citizen foreign medical graduates applied for residency training beginning in July, 1985. These figures show the present demand by foreign medical graduates for residencies. Their wish, however, is not often fulfilled. Of the 7,000 alien foreign medical graduates, 4,200 were in the final match, and of these, only 900 (22%) matched. U.S. citizen foreign medical graduate applicants fared somewhat better; of 1,700 in the final match, 700 (40%) matched.

Thus, the aspiration of foreign medical graduates for graduate medical education in the United States remains very strong. Alien physicians appear undaunted by the obvious decreasing opportunities for training, and the number of U.S. citizen foreign medical graduates seeking ECFMG certification increases annually. Data compiled by Mick and Worobey from American Medical Association sources show that the

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[1] Candidates in other groups obtaining matches included: Canadian students, U.S. physicians, osteopaths, and those in Fifth Pathway programs.

ratio of alien to U.S. citizen foreign medical graduates obtaining residency positions is changing. These data are shown in Appendix II.

I do not understand the apparent preference of program directors for U.S. foreign medical graduates over alien foreign medical graduates in filling vacant residency positions. There has been widespread criticism of the offshore schools catering to Americans. Some of these schools have questionable standards for admission of students, inadequate educational and library facilities, and small faculties. In some schools there are no facilities for clinical study and students obtain such experience "catch-as-catch-can" in small U.S. hospitals and clinics.

In my opinion, an exact match between the number of physicians graduating from LCME-accredited U.S. schools and the number of first-year residency posts would be difficult to attain in our society. The Accreditation Council for Graduate Medical Education and the Residency Review Committees examine periodically every residency program. The number of positions offered in each program must meet the need in each hospital. At present, the number of positions offered nation-wide exceeds the number of graduates of U.S. schools by about 3,000, and these remaining posts are filled by foreign medical graduates. A sudden decrease or increase is, I believe, unlikely.

A recent Private Sector Conference at Duke University Medical Center examired the question, "How Many Doctors Do We Need?" Attendees included representatives of industry, medical schools, universities, medical organizations, law, health care and insurance organizations, and others. No consensus was reached. Although concerns of a forthcoming physician surplus were strongly expressed by some, others felt the market will govern the number of physicians entering practice.

Many medical organizations are facing the issue of the increasing numbers of Americans enrolled in medical schools abroad in programs of study that clearly do not match those offered in state-side medical schools. The numerical output each year of new U.S. citizen physicians from these schools is equivalent to that of about a dozen U.S. LCME-accredited schools. It is not the duty of ECFMG, nor is it feasible, for ECFMG to inspect these offshore or any other foreign medical schools. We can, however, and we do inspect the product of the schools, and as the gatekeeper for entry of foreign medical graduates into American graduate medical education, we make certain that every applicant has proper credentials and meets the examination standard set for students in U.S. schools. Thus, ECFMG assures the quality of individual physicians.

But ECFMG is not the end of the line in quality assurance. Program directors observe and supervise the clinical work of foreign medical graduates and guide their continuing education. Moreover, it should be pointed out that state licensure of medical residents is required in most states. Member State Boards of the Federation of State Medical Boards also follow a national standard in examining and granting licensure to foreign medical graduates.

Incidentally, I call attention to the fact that neither ECFMG nor any other organization, to my knowledge, has information on the current activities of thousands of foreign medical graduates who have been unable to obtain ECFMG certification. They are "medical doctors" with valid diplomas of graduation from foreign medical schools, but lacking ECFMG certification are not permitted to enter graduate medical education or obtain licensure to practice. Among these are many American citizens and many foreign-born physicians who have gained permanent residency status in the United States on a family preference or refugee basis. What kinds of occupation are these thwarted doctors engaged in?

Finally, I point to a weakness in our programs in graduate medical education for foreign medical graduates, especially alien physicians. It is well recognized that most foreign medical graduates who successfully enter graduate medical education through the residency matching program or otherwise, obtain positions in less strong training programs. They take positions that do not attract graduates of our U.S. schools. They go to big metropolitan hospitals in unattractive sections of large cities or to rural hospitals far removed from university settings. They enter training programs less sought after by our graduates, such as anesthesiology, pathology, psychiatry, physical medicine, nuclear medicine, and therapeutic radiology. In fairness, it must be stated that all these programs are fully accredited by ACGME and Residency Review Committees.

I am less concerned about the American citizen foreign medical graduate and the permanent status alien foreign medical graduate in these less strong programs than I am about the well-qualified alien foreign medical graduate who has come to the United States to prepare for a career in his or her home country. These latter physicians should train in our very best centers. At present, many of them who have been in weak programs return home disillusioned about the superb educational facilities they earlier thought existed here.

In his letter to the editor of the Journal of the American Medical Association (Vol. 250, p. 2604, 1983), Dr. Donald Louria of the New Jersey Medical School stated that "it is morally indefensible to be unwilling to train physicians from less medically sophisticated parts of the world." He proposes that 10 percent of positions in all programs be allocated to alien foreign medical graduates who return home after training, in keeping with current public law. Louria adds that "the most prestigious [hospitals] would be able to select the best of the foreign applicants...It would benefit the country of origin and will provide a pool of physicians for the physician-intensive hospitals who will not flood [our] communities on completion of their training." Louria's point is well taken.

Others have promulgated similar ideas to improve the role of the United States in international medicine. At present, we are lax in using our talents and resources to the greatest benefit of human kind. I do not propose that providing graduate medical education for alien physicians is a responsibility of this Subcommittee. It is a responsibility of our profession and our Government as a whole and, indeed, of foreign governments. There are ways to finance the education of alien FMGs that have not been fully explored and that would not be a further drain on our economy.

Thank you for the opportunity of presenting ECFMG and other data and my views.

Senator QUAYLE. The final witness on this panel is Dr. Alfred Gellhorn, director of medical affairs of the New York State Health Department.

Dr. Gellhorn?

Dr. GELLHORN. Thank you very much, Senator Quayle, and Senator Simon.

I do thank you for letting me be here. I found it very difficult to restrain myself during the previous panel, having been a professor of medicine and dean of the University of Pennsylvania School of Medicine. But I will restrict my comments as requested to the foreign medical graduate issue.

I am also chairman at the moment of a Governor's Commission on Graduate Medical Education in the State of New York. This commission has been charged to make recommendations regarding the residency training of foreign medical graduates. At the present time, as indicated by Senator Simon, approximately 38 percent of the 11,000 residents in New York State are foreign medical graduates. In contrast, only 18 percent of the residency positions in the whole United States are filled by graduates of foreign medical schools.

Before analyzing the drawbacks of such a high proportion of FMG's in residency positions, it is important to understand the basic issue: Residents carry the responsibility for the care of patients to a very great extent, despite the fact that they are supervised by more experienced physicians.

Residents provide around-the-clock coverage of patients, and about 80 to 85 percent of the time, they are on their own. Many of us who have been through residency training recognize that more decisions are made affecting the health, the life and limb of patients during this period of intense experience, with the multiple, varied, and serious medical problems which arise than may face the majority of us during the remainder of our professional life.

It is therefore critically important that before a young physician begins his/her residency, he/she must be appropriately educated to meet the serious responsibilities of the training. And here is the risk when it comes to foreign medical graduates.

There are more than 1,400 medical schools throughout the world, and for the most part, there is no national or international mechanism to monitor or evaluate the quality of the medical education provided. In the United States and Canada, an independent organization, the Liaison Committee on Medical Education, carries out an in-depth evaluation of every medical school at 7-year intervals. The only quality control of foreign medical schools has been examinations conducted by the Educational Commission on Foreign Medical Graduates, as Dr. Asper has indicated. These examinations were in two parts—one to test competency in English, and the other, competency in medicine. Despite the fact that these examinations were recognized to be far less comprehensive and searching than the national medical boards which U.S. medical students take before starting residency training, only 50 percent of those taking the ECFMG examinations for the first time in 1980 passed, and for the repeaters, some taking the examination more than 10 times, only 25 percent passed.

In July 1984, the new examinations, which Dr. Asper has mentioned, were instituted, and the overall pass rate of that first group was only 17 percent. These are analogous to our national board examinations, which 85 percent or more of U.S. medical students pass before they start their residency training.

There are foreign medical graduates in the United States who are nationals of another country. These are now designated alien foreign medical graduates, AFMG's. Then, there are U.S. citizens who have failed to gain admission to U.S. medical schools, go to another country for their medical education, and these are the U.S. FMG's.

In the early seventies, when competition to go to medical school began to grow, disappointed applicants from the United States went to Western Europe—particularly Italy, Belgium, and Spain, and also to medical schools in Guadalajara in Mexico. Soon the European schools, pressed by their own citizens, virtually excluded foreigners. The success of Guadalajara to attract U.S. citizens spurred the creation of proprietary medical schools elsewhere in Mexico and particularly the Caribbean, as has been mentioned by Dr. Grant. Fourteen of these offshore medical schools were formed in a decade, and they were for the most part an immediate financial success. These schools received a charter to grant the M.D. degree from their country of residences, but they also have offices in the United States. The admission requirements are lenient, to put it mildly, and credit is given for other academic work or experience. In many instances, the laboratory, library and study facilities are very limited, and the full-time faculty who are qualified to teach is small—frequently supplemented by visiting U.S. medical school lecturers, not unusually during the winter months in the United States.

Most notably, clinical facilities are essentially nonexistent, and therefore, it has been necessary for students from the Caribbean offshore medical schools to obtain clinical clerkships for the third and fourth year of medical school in the United States.

In New York, because of this, the State education department has instituted regulations which require that before a clerkship can be entertained in New York, the school must be approved by the State education department.

The Commission on Graduate Medical Education has followed this up by stating that every foreign medical graduate from a school that does not have its own clinical clerkships must be approved by the State education department before they can undertake a residency in New York State; further, that for all foreign medical graduates, the FMGEMS, the new examinations, must be passed within three tries, and if unsuccessful, the student is no longer eligible for residency.

Finally, the Commission will encourage the Commission on Foreign Medical Schools created by the Federation of State Medical Boards, which has been constituted like our own LCME—the Liaison Committee on Medical Education—to make the same sort of study of the foreign medical schools and make this available.

Just one other point that I would like to comment on which is related to your previous panel. If there is a reduction, either through Senator Quayle's suggestion or by the mechanism which

we will be employing in New York, of foreign medical graduates in residency positions, it will be necessary for the major medical centers, which were represented by Dr. Heyssel and others, in New York, by Columbia Presbyterian, Mount Sinai, and so on, to redistribute the existing house officers so that there will be available in those hospitals which now have FMG's and are giving training in primary care, to have residency positions there as well.

Thank you very much.

Senator QUAYLE. Thank you very much, Dr. Gellhorn.

[The prepared statement of Dr. Gellhorn follows:]

March 25, 1985

TESTIMONY ON FOREIGN MEDICAL GRADUATES BEFORE SENATOR DAN QUAYLE'S SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY BY DR. ALFRED GELLHORN, NEW YORK STATE DEPARTMENT OF HEALTH

My name is Alfred Gellhorn and I appreciate the privilege to comment before this Committee. At present I am Director of Medical Affairs in the New York State Department of Health and Chairman of New York State Commission on Graduate Medical Education. It is not necessary to note that I am very grown up but my qualifications include twenty-five years at the Columbia University College of Physicians and Surgeons as a Professor of Medicine and Director of the Institute of Cancer Research, a stint as Dean of the University of Pennsylvania School of Medicine, First Director of the School for Biomedical Education of City College of New York, and after retirement Visiting Professor at the Harvard School of Public Health for three years before joining the New York State Department of Health.

The USA has had an inconstant relationship with foreign medical school graduates. In the 1960's and early 1970's we encouraged foreign physicians to come to our country to meet the demands for greater access to medical care and, after 1965, to fill the surplus residency positions which were created in the wake of the Medicare legislation. The immigration laws were made very permissive so that in 1973, the peak year of foreign physician influx 7,907 of the 8,145 were admitted as immigrants. In this early period, 43 percent came from the far East, predominantly India and the Philippines, 23 percent from Western Europe, 19.5 percent from Canada and Latin America and the remainder from other countries. A negligible proportion of these foreign medical school graduates were U.S. citizens who had sought medical education in a foreign country.

In 1976, Congress revoked the preferential professional inducements provided in the earlier amended Immigration and Nationality Act, and in Title VI of P.L. 94-98 stated "...there is no longer an insufficient number of physicians and surgeons in the United States." By 1978 the number of immigrant physicians admitted to the U.S. had dropped by one half to 4,435 and the distribution of the "brain drain" had changed significantly. Now only 12 percent came from the well qualified European medical schools, whereas those from Asia had increased to 52.5 percent. Still, however, there were very few U.S. Foreign Medical School Graduates.

Congress' intent to slow the influx of foreign trained physician was in part predicated on the encouragement which it was giving to increase the production of U.S. medical school graduates. Fiscal incentives were provided to medical schools to increase enrollment and also generous grants were given for the creation of new medical schools. The response was prompt and enthusiastic with the result that in the decade of the '70s, medical school output doubled from about 8,000 graduates to 16,000. But now another phenomenon appeared which kept physician production growing beyond reasonable limits. To the slowed, but persistent stream of alien foreign medical school graduates (AFMGs) and the enhanced stream of U.S. medical school graduates (USMGs), there began to appear a trickle, now swelling rapidly, of U.S. citizens who obtained an M.D. degree from foreign medical schools (USFMGs). Why has this happened?

Two major factors were probably operative. First was the coming of medical school age of the post World War II "baby boom." The second factor was the enactment of the Medicare and Medicaid legislation by Congress. This had an impressively favorable impact on physician's income which, combined with the social prestige of the profession, made medicine one of the most popular career aspirations of young Americans (and/or their parents) in the 70's. So desirable, in fact, that many of those who failed to gain admission to a U.S. medical school enrolled in a foreign medical school where admission qualifications and competition were less demanding. In the late '60's and early '70's the medical schools in Europe were principally selected by Americans, often after paying a fee to an agency in the U.S. which facilitated the matriculation. Shortly, however, the pressure of U.S. students was too great on the already overcrowded medical schools in Italy, Belgium and Spain particulary, and admission of foreigners was halted or very drastically curtailed.

The medical schools in Guadalajara in Mexico had always been a popular institution for disappointed North American medical school applicants and its financial success combined with the rising U.S. student demand, stimulated the creation of a number of "off-shore" enterprises in the Caribbean which were given charters by the country of residence to bestow the M.D. degree. These schools are proprietary and, although foreign chartered, they operate in the United States. Table 1 lists the schools, almost all of which were developed within the past decade, and their U.S. addresses.

TABLE 1

A PARTIAL LIST OF FOREIGN-CHARTERED MEDICAL SCHOOLS WITH OFFICES IN THE UNITED STATES, 1984

COUNTRY WHERE CHARTERED	MEDICAL SCHOOL	U.S. ADDRESSES
Antigua	University of Health Sciences Antigua	Atlanta, GA.
Dominica	Ross University (Formerly University of Dominica)	New York, NY
Dominican Republic	CIFAS University	Los Nietos, CA
Dominican Republic	Universidad de Nordestana	Brooklyn, NY
Dominican Republic	Universidad Technologica de Santo Domingo (UTESA)	Whittier, CA
Dominican Repuiblic	World University	Washington, DC
Grenada	St. George's University	Bay Shore, NY
Mexico	Universidad Automona de Guadalajara	San Antonio, TX
Mexico	Universidad del La Salle	New York, NY
Mexico	Universidad del Noreste	New York, NY
Montserrat	American University of the Caribbean	Miami, FL
St. Lucia	Spartan Health Sciences University	El Paso, TX

* From Imperato, P.J. An overvew of New York State and the off-shore medical schools. NYS J. Med. 1984; 84:337-344

The quantitative impact of these flows of foreign medical school graduates can be characterized in several ways:

a) Table 2 shows the number of FMGs in New York and New Jersey residency positions as a proportion of all residents in these states and contrasts this with the entire U.S.

b) A survey of all hospitals in New York State with approved residency programs revealed that 25 of the 86 hospital (29 percent) had 60 percent or more FMG residents. When these data were further refined it was found that the residency programs with a smaller number of residents have a higher proportion of FMGs than large residency programs.

c) In New York State one year of residency training is required for graduates of U.S. medical schools before they are eligible for licensure; foreign medical school graduates (FMGs) must have three years of residency training to quality for licensure. Table 3 shows the countries from which come unlicensed physicians in residency training in New York State.

TABLE 2

NUMBER OF FMG RESIDENTS AND THEIR PERCENT OF TOTAL

	1979		1982		1983	
	No.	%	No.	%	No.	%
New York	3,799	43.1	4,147	40.4	4,028	38.2
New Jersey			1,139	61.4	1,224	64.0
U.S.	12,065	20.2	13,123	19.0	13,221	18.4

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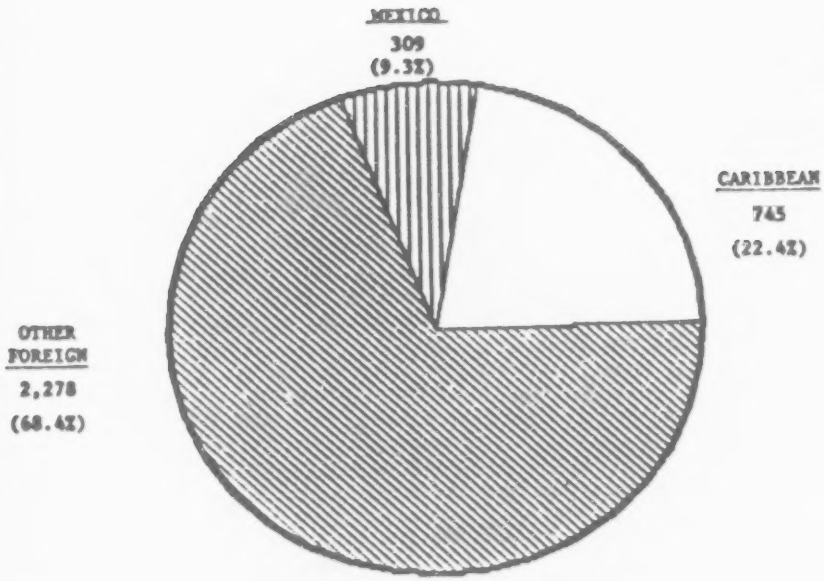
* It is to be noted in passing that although the absolute number of FMG Residents in New York increased from 1979 to 1983, the percentage of the total is less in 1983 than in 1979. This reflects the continued growth of residency positons from 8,184 to 10.544.

TABLE 3

FMGs UNLICENSED PHYSICIANS IN RESIDENCY TRAINING IN NEW YORK STATE (1984)

Country	Number	Percent of Total
India	631	10.6
Dominican Republic	363	6.1
Mexico	309	5.2
Philippines	273	4.6
Grenada	181	3.0
Italy	174	2.9
USSR	138	2.3
Dominica	81	1.5
Spain	68	1.4
South Korea	66	1.1
Israel	55	0.9
Montserrat	55	0.9
France	52	0.9
Poland	50	0.8
Other Countries	836	14.1

d) The tabular material of Table 3 can be graphically represented:



Source: Department of Health 1984 Survey of Unlicensed Physicians

Note: This figure includes only graduates of non-U.S. medical schools who were unlicensed residents at the time of the Survey. Of 5949 unlicensed residents, 3332 were graduates of foreign medical schools.

e) For the selection of first year residents, the teaching hospitals participate in a matching program administered by the National Resident Marching Program. Table 4 indicates the proportion of U.S. medical schools graduates, U.S. foreign medical school graduates and alien foreign medical school graduates who obtained residency positions in New York and New Jersey through the "Match" in 1984.

TABLE 4

	USMG	USFMG	AFMG
New York	77.9%	10.5%	11.6%
New Jersey	60.0%	32.7%	7.3%

As can be seen the proportion of U.S. foreign medical school graduates constitutes a very significant part of the total foreign medical school graduates in the first year of residency training. In addition many residency positions are filled ouside of the match by foregin medical graduates so that 38 percent of all residents are FMGS.

f) In New York, the number of new foreign medical graduates who are licensed to practice is falling, probably related to the restriction on immigration of alien doctors. The decline is shown in Table 5.

TABLE 5

NEW PHYSICIAN LICENSURES IN NEW YORK STATE BY PLACE OF MEDICAL EDUCATION

Year	New York State	Other U.S.	Foreign	% Foreign
1973-74	782	862	2,158	56.8
1977-78	936	961	1,786	48.5
1983-84	1,224	1,224	1,594	39.2

The Issue

The central issue is the quality of preparation of the foreign medical school graduate. Are the FMGs appropriately educated to assume the responsibility of the residency experience which often involves decisions affecting life and health? Is medical education equivalent in all medical schools regardless of country? How do U.S. medical schools differ from foreign medical schools?

1) A critically important difference is immediately apparent. All U.S. and Canadian medical schools are carefully and objectively evaluated in depth at seven year intervals by the Liason Committee on Medical Education. The survey includes a detailed documentation of a self study which covers the curriculum, the qualifications of the faculty, the characteristics of the student body, the basic science and clinical resources, finances, governance and relationship with the parent university. After examination of this elaborate data, an on-site visit team consisting of medical educators and staff spend 2-4 days verifying the reported information and, through independent discussions with the students, faculty and administration as well as facilities inspections, develop additional data. At the end a comprehensive report is prepared which is reviewed by an independent commission and approved or approval with conditions follows. Recommendations for improvement are frequent.

   In contrast, the quality of the medical education in foreign medical schools is, for the most part, not monitored by either national or international accrediting organizations.

2) The newly created medical schools in Mexico and the Caribbean "off-shore medical schools," have completely inadequate clinical facilities for medical student instruction in physical diagnosis, history taking or the initial basic clinical exposure to medical problems. Most of these schools, therefore, must send their students elsewhere (usually to the U.S. and very frequently to New York) for Clinical Clerkships which constitute the major part of the third and fourth year of medical school. Because these clerkships were often unsupervised either by the hospital personnel or anyone related to the medical school, and because there was no continuity in the correlation of the basic medical sciences with clinical medicine, the New York State Education Department established a regulation which required that any medical school utilizing New York hospitals for major clerkship experience must be approved together with the hospitals providing the clinical instruction. To date only two medical schools have been so approved: Universided Del Noreste in Tampico, Mexico, and Universidad Autonoma de Guadalajara, Mexico. Two offshore medical schools have been disapproved: Ross University on Dominica and the American University of the Caribbean on Montserrat. The basis for the disapprovals rested on serious administrative inadequacies, rudimentary and insufficient library facilities, absent or inadequate laboratory experience, questionably qualified or unqualified faculty in a number of the basic science departments, and complete separation of the basic science and clinical instruction.

3) There are some fourteen hundred medical schools throughout the world and most of these presumably provide all components of undergraduate medical education. Anecdotally and by unofficial observations it is known that in many instances the size of the medical school classes preclude meaningful laboratory or clinical experience, and personal contact with faculty is a rarity. In the absence of independent

assessment of characteristics or quality of education recourse has been assigned to multiple choice examinations administered by the Educational Commission on Foreign Medical Graduates (ECFMG). A measure of the adequacy of the medical school preparation is shown in Table 6 which records the results of examinations for the period 1975-1980.

TABLE 6

ECFMG EXAMINATION EXPERIENCE

	1975-76		1979-80	
Type of Examination	Number Examined	Percent Passing	Number Examined	Percent Passing
Initial Examination	9,304	55.6	4,803	49.9
Repeat Examinations	7,267	23.0	4,774	24.7

This demonstrates the high prepartion of "repeats" (as many as ten times or more) and the relatively small number from the total taking the examination which are finally certified to begin residency training in the U.S.

The ECFMG examination has been criticized because it pales in difficulty when compared with the U.S. National Boards which the majority of U.S. medical students take, and which more than 85 percent pass on the first try. Beginning in July 1984, therefore, the ECFMG has introduced the Foreign Medical Graduate Examinations in the Medical Sciences (FMGEMS) which use the National Board bank of questions and are closely related. The results of the first examination showed that only 17 percent of graduates of foreign medical schools passed! Clearly the FMGEMS will be a more rigorous test of the cognitive knowledge of FMGs but it is generally agreed that such tests are not a completely satisfactory substitute for a critical evaluation of an educational program.

Other Issues

There are other issues which have been raised in the discussion of foreign medical graduates but these skirt the critical central issue of the quality of the education. For purposes of completeness, however, they must be mentioned.

1) It has been agreed that many FMGs accept residency positions whch are not sought by U.S. graduates either because the environmental conditions of the hospital are unattractive or the quality of the educational experience is poor. In such situations the FMG is providing patient care which might otherwise not be available. The statement is, in part, fact. It does not, however, justify the use of FMGs but rather emphasizes the necessity of providing mechanisms for a more equitable distribution of qualified medical school

graduates. The use of poorly prepared FMGs, with language difficulties and cultural alienation perpetuates the discrepancies in care which too often, means poor care for poor people.

2) It has been agreed that the use of residents including FMGs reduces the cost of medical care by providing cheap labor. Work weeks of 60-100 hours are not unusual for residents and this reduces the need for other health personnel. It is hard to quantify the cost of exhaustion on the medical care of patients but those who have experienced the long and demanding hours know errors of judgement in commision and omission are common and potentially disastrous. This is an indefensible economy.

3) There are those that argue that FMGs may be good because, when licensed to practice, they will inrease competition within the professions so that there will be a better geographical distribution of doctors, physicians fees will decrease and even house calls may return! It so happens that physicians can maintain their income level and the excess number of physicians will increase unnecessary medical procedures, tests, hospitalizations and office visits. If the FMG starts off with a poor medical education followed by residency training of lesser quality, the care that will be rendered is likely to cost more and be less than optimal.

4) It has been postulated that FMGs will provide primary care in underserved communities. Mick of the University of Washington conducted a 10 year longitudinal study which found that FMGs become specialists and migrate to the Sun Belt just like their USMG counterparts. They are less often in cities over one million and whereas USMGs tend to practice in suburban communities, FMG tend to practice in comparable sized towns which are away from the cities.

Discussion

The issue of foreign medical graduates relates to the responsibility of government to protect the public from medical practitioners whose undergraduate and/or graduate medical education does not meet the quality standards which are required of U.S. medical school graduates. To supplement rhetoric with a reasoned argument it is important to state the fundamental purpose of undergraduate medical education. The factual material of the basic science courses has a variable life expenctancy but it is accepted that much of it will become obsolete. The basic sciences are, however, a fundamental constituent of medical eduation because they teach the scientific method of defining a problem, gathering evidence objectively, formulating a hypothesis, verifying the hypothesis by independent means presenting the data and conclusions for peer review. The application of the scientific method in the critical examination of evidence and problem solving is fundamental to the good practice of medicine.

The study of basic sciences also provides a vocabulary and concepts upon which the individual can understand new theories and facts and can continue to be a perennial student of medicine.

The clinical clerkships of undergraduate medical eduation provide the student with the opportunity to learn the basics of the patient-physician relationship under supervision. The interrelationships between the basic sciences and clinical medicine which are strong or tenuous can be explained and through conferences in a university setting the enlarging breadth of the health field can be glimpsed.

Undergraduate medical education is one major factor in the production of a good physician. In the U.S., undergraduate medical education is under constant scrutiny and revision -- and never more so than at present. The public whose life and limb are, in part, dependent upon competent medical care should be assured of the basic educational qualifications of those who are serving them.

The evidence of poor undergraduate medical education in the new proprietary medical schools of the Caribbean is impressive. And it is to these that the majority of U.S. students are going. The quality of education at other schools throughout the world from which come the alien foreign medical school graduates may be suggested by the results of the FMGEMS but other measures should be initiated. A mechnaism has been proposed by the Federation of State Medical Boards.

State Medical Boards, which, in the main, are responsible for medical licensure, are acutely aware of the inadequacy of their information when it comes to fulfilling their resposiblity regarding FMGs. A proposal which has been approved by fifty-three of the fifty-four states and territories of the U.S. is to create a Commission on Foreign Medical Education under the auspices of the Federation of State Medical Boards. This Commission, with membership and data collection procedures patterned after the Liason Committee on Medical Education, will gather the requisite information including a site visit of any foreign medical school which requests it. This information wll then be made available to any State Medical Board on request and each Board will make an independent determination regarding the acceptability for licensure consideration of the Graduates of the Foreign Medical School.

Conclusion and Recommendations

If it is accepted that the quality of medical education in foreign medical schools, whether "off-shore" or elsewhere, is difficult to assess, what measures could be taken to control the influx into graduate medical education of those unqualified to assume the responsibility for patient care in a residency?

In New York the Commission on Graduate Medical Education has made the following recommendations to the Commissioner of Health:

I. A graduate from a foreign medical school which does not provide full clinical training in its own country may not be appointed to a residency in a New York hospital unless that school has been found

acceptable by the New York Education Department for purposes of clinical clerkships in New York.

II. A graduate of a foreign medical school must pass the FMGEMS (Foreign Medical Graduate Examinations in the Medical Sciences) within the first three attempts in order to be eligible for a residency in New York.

III. The Commission on Foreign Medical Education, appointed by the Federation of State Medical Boards, is to be encouraged and its findings should be used in evaluating the acceptability of a foreign medical school's graduates for residency training.

Additional Suggestions to Congress

It is suggested that guaranteed loans for U.S. students attending foreign medical schools should be discontinued. There has been a steady decline in the medical school applicant pool in recent years such that in this year there are less than two applicants for each available medical school position. Under these circumstances, and in view of the oversupply of physicians, it does not appear reasonable for U.S. students who have failed to gain admission here to be supported abroad.

Senator QUAYLE. Dr. Grant, do you have a time problem with your plane? I was informed on that.

Dr. GRANT. Yes, Senator.

Senator QUAYLE. Let us go ahead, and we will ask you questions, and I will yield to Senator Simon. Then we will take the other two panel members, so you can be excused.

I wonder if you might be able to give us the bottom line finding of GAO that, I believe, concluded that the clinical training received in the foreign schools is inferior to what they receive in the schools here, within the continental borders of the United States.

Could you amplify on that particular inferiority criterion that you have found with these schools?

Dr. GRANT. Yes, Mr. Chairman, I can give you a couple of specific examples that come to my mind. At one medical school that we visited, there were 13,000 medical students. The average medical school in the United States has several hundred medical students. For every medical student in the United States, you usually require seven hospital beds per student, in order to provide adequate clinical training. In other words, if you take your 13,000 students in this particular school I am mentioning, they would have required 91,000 hospital beds. They had, if my memory serves me correctly, 3,400 instead of 91,000.

Some of the medical schools we visited had no clinical training facilities whatsoever and, as Dr. Gellhorn indicated, endeavored to use some of the hospitals in the United States, many of which, at least the ones we visited, were not affiliated with medical schools and whose training—at least, in our view—left much to be desired.

So that it was our view in general that the most serious deficit presented by the medical schools we visited revolved around their lack of clinical training facilities.

Senator QUAYLE. Despite the lack of clinical training facilities, they have to go through some tests to be admitted into residency or internship with hospitals in the United States. Do you believe that those tests are basically very difficult to pass whether they have

received the proper clinical training, or do you believe that the tests are inadequate? Because what you are saying is that there is inferiority, yet when they come back, and I presume that the tests—and we can get into that with Dr. Asper later—that the tests are trying to establish some norm of expectations of what a person coming out of medical school should have, and if they pass those tests, then they are admitted. But I presume from your testimony that you would still say that, by and large, these students have an inferior education, and aptitude, once they get into the residency requirements. So there is still a missing element there, and I wonder if you have any comment on that.

Dr. GRANT. Yes, Mr. Chairman, I believe I understand your question. I would respond by saying that while I think there is considerable value in some of the kinds of testing procedures that have been outlined here today, it is my view that there is no test that can substitute for the rigorous training and undergraduate discipline that is received at a good medical school, and I believe further that it is possible for an individual who is sufficiently bright or sufficiently adept at boning up for an examination to pass such an examination in the absence of adequate training. Therefore, I do not believe that the examination by itself is sufficient.

Senator QUAYLE. Is there an additional examination that you could give, or are you saying basically, because of that example you gave us of 13,000 students that would have 91,000 beds, that there is just absolutely no way on a comparative basis that they can have that clinical training, understanding, in-depth knowledge that a student who graduated from an LCME approved school has?

Dr. GRANT. I think it brings out the point that unless you have a system developed to properly evaluate the kind of training these individuals receive and to accredit the training they have, there is no realistic way, I believe, by which one could substitute just an examination for that process.

Senator QUAYLE. Senator Simon.

Senator SIMON. To follow up on my colleague's questions, you say on page 3 of your testimony, talking about foreign medical schools, "None of these schools offered a medical education comparable to that available in the United States."

Then on page 8 of your testimony you say:

> We are aware that a few states have taken actions in an effort to assess the quality of training received in some foreign medical schools as well as their undergraduate clinical training in U.S. hospitals.

Are you talking about an assessment beyond what Dr. Asper is testifying to?

Dr. GRANT. Yes, I am, Senator.

Senator SIMON. And what States are you talking about?

Dr. GRANT. Well, for example, Dr. Gellhorn mentioned in New York State, they have a problem—that he, more probably, can talk about much better than I can, obviously—to assess the training provided in some of the medical schools abroad and particularly to establish certain requirements concerning the kind of training these students receive in hospitals within New York State. There are some other States that have done things similar to that. We are in the process at the present time, Senator, of updating all of

that information, so I am not really prepared to discuss that in depth. But that is what we will be able to do, I hope, by July of this year.

Senator SIMON. Thank you, Dr. Grant.

Thank you, Mr. Chairman.

Senator QUAYLE. Thank you very much, Dr. Grant, and we will excuse you to catch your plane.

Dr. GRANT. Thank you.

Senator QUAYLE. Dr. Asper, do you want to make any comments on the statement that Dr. Grant and GAO had that it is very difficult, almost impossible, to test for clinical training and aptitude, and do you also agree with his assessment that these students are a product of inferior education compared to your stateside students?

Dr. ASPER. Well, Mr. Chairman, as you know, in the United States, our own medical schools have no method of testing the clinical ability of our students. And when students graduate from our schools, according to the LCME guidelines, the faculty members who have worked with those students throughout their clinical years must state that the students have adequate clinical ability.

There have been many groups that have attempted to measure clinical talents or clinical ability and have failed: Such prestigious groups as the American Board of Internal Medicine had a clinical test for a number of years, but finally gave it up.

At the present time, we at ECFMG are trying to develop a clinical test that would follow the test of cognitive knowledge, and we are going to try it out this June in a limited way in New Jersey, on about 300 FMG's. I am not sure whether it will be successful, in view of the past experiences of others in testing clinical skills.

It is certainly true, we believe, that it is possible to pass our current ECFMG examination by boning up on one's medical knowledge, but certainly, medical education must continue throughout the period of clinical training. After all, ECFMG is only the gatekeeper to the clinical training, and that clinical training has to be carried out under supervision in the programs that Dr. Gellhorn described.

So we think that program directors who accept foreign medical graduates have a major responsibility to look toward the clinical training of the FMG's. But this is a very important area to which you refer.

Senator QUAYLE. Dr. Asper, in the past 6 or 7 years or so, have we seen a continual increase in the number of FMG's, and if so, do you have any statistics or numbers of what it has gone from, say, in 1978-79 up until 1984, or maybe even documenting further back? In other words, my question is—I sort of gather that the answer will be that there has been an increase—I guess my question is how much of an increase do we have?

Dr. ASPER. Well, the increase in foreign nationals applying for ECFMG certification is not very striking.

Senator QUAYLE. Foreign nationals—those are people from other countries that are going to come over here for their residency training and then return?

Dr. ASPER. And go home again, yes.

Senator QUAYLE. Let me put that aside. I guess the proper terminology of that is alien FMG's, if I am correct. Let us put that aside. Let us talk about the FMG's, those that do not get into medical schools here in the States, by and large, and then go offshore. I refer to it as offshore——

Dr. ASPER. That is correct, offshore schools.

Senator QUAYLE. Offshore schools. Now, has there been a substantial increase in that number of students?

Dr. ASPER. Senator, the figures are dramatic. In 1976, there were 2,000 U.S. citizens who took the ECFMG examination, and by 1983, the number had grown to 7,300.

Senator QUAYLE. I think that in and of itself is a rather dramatic statistic.

Dr. Gellhorn, you mentioned that you restrained yourself in your comments of the panel beforehand, and at the end you added a little bit. Are there any general comments or observations you wanted to make on some statements of fact or opinions that were made?

Dr. GELLHORN. Well, the last question that you asked Dr. Relman related to how one would achieve the objectives which you and Senator Simon and others have indicated as being desirable.

Dr. Relman was suggesting some sort of a national body, possibly quasi-governmental, I think, suggested by Senator Simon. I think, along with Dr. Daly, that one is going to have to have that, but I believe it is going to have to be at the State level, for just the reasons that he gave. There is such an enormous difference between Indiana, let us say, and New York, or California, and Illinois, that to try to be sensitive to all of the issues in each one of the States would be very difficult. On the other hand, why not at the State level? And one of the recommendations that is emerging from the Commission on Graduate Medical Education is that in New York, we will develop such a body that is quasi-governmental, because it may have to be credentialized by the legislature. But it would have broad representation with the public and with the profession and governmental officers, as well, that would operate on a year-by-year basis to consider what are the issues in terms of numbers, the distribution within specialties, the geographic distribution and so on.

Senator QUAYLE. So in other words, instead of having the focal point being the university and its affiliates, you would have a State mechanism?

Dr. GELLHORN. I think that the record of the medical schools of which I have been a part have not been spectacular.

Senator QUAYLE. OK, fair enough. What percentage of FMG's does the State of New York have?

Dr. GELLHORN. Thirty-eight percent.

Senator QUAYLE. Indiana, according to Dr. Daly, had 4 percent, which is quite a disparity. I would presume in some of your hospitals, it gets as high as how many.

Dr. GELLHORN. There are 26 percent of our hospitals that have more than 60 percent.

Senator QUAYLE. That have more than 60 percent.

Dr. GELLHORN. Also, there is just one thing I thihk I would like to correct. Alien foreign medical graduates do not necessarily

return to their countries. In New York State, for example, the proportion of foreign medical graduates which has been decreasing over the years nevertheless is now, in 1983-84, 39 percent were licensed as foreign medical graduates, and the distribution between foreign, that is, alien foreign medical graduates and U.S. foreign medical graduates is now about 50-50. So you still have a very significant number of those nationals of other countries who come to this country and stay. Therefore, if one is going to do anything with regard to restricting, you have to make some appropriate provisions that they do return.

Senator QUAYLE. Well, let me go back. Dr. Asper said in 1983, he had 7,300 FMG's.

Dr. ASPER. U.S. FMG's.

Senator QUAYLE. U.S. FMG's. Now, we did not have 7,300 alien FMG's, too, in 1983. When you say a 50-50 breakdown, I presume you are talking about in the——

Dr. GELLHORN. I am talking about licensure in the State of New York.

Senator QUAYLE. Yes, licensed. But applications coming in, do you know what the figure is on the alien FMG's? It is much smaller, isn't it?

Dr. ASPER. Much larger, Senator.

Senator QUAYLE. Larger than 7,300?

Dr. ASPER. Yes, indeed—19,850 examinations administered to alien FMG's in 1983.

Dr. GELLHORN. It is just that the proportion of the U.S. FMG's is going up, but the number of alien foreign medical graduates is not decreasing. It is holding more or less constant.

Senator QUAYLE. OK. Dr. Gellhorn, if in fact the policy objectives of what we are trying to achieve, shifting more into the primary care and correcting specialty maldistribution which is the objective and priority of what my proposal will direct itself to—if that is the case, and if you accept the assumption—and maybe you do not—that your graduates of the offshore schools, are not of the high quality LCME approved schools produce—I guess that is a given fact that everybody would agree to—and therefore, some of the FMG's, you said, 20 percent of your hospitals had over 60 percent, I believe, FMG's—I presume many of those hospitals are in the urban areas and the poorer districts, and therefore, you can make the analogy that a poorer quality of doctors are unfortunately attracted to the poorer areas, and therefore, in the quality of care, there is a certain distinguishing factor.

Thus, what we ought to do is to try to focus on our training programs within the hospitals themselves to elevate those training programs to be able to attract better people to those hospitals; by attracting to those hospitals people of a higher caliber, the quality of care is going to be better, and we will have less disparity within the health care system, depending on where you live.

If, in fact, that is the case, and all the assumptions I have stated are correct, which I believe they are, then it would make sense that we might be able to improve the quality of care for the poorer areas of our country by shifting to primary care at a percentage, or whatever mechanism we may use, because a number of the U.S.-trained physicians are not going to be able to get in to many of

those hospitals that they are accustomed to going, and therefore, in search for a hospital to locate, they are going to see a change in the ratio in some of these hospitals that presently are over 60 percent may, in fact, go downward, and you would have more U.S.-trained physicians in there. And if that is the case, U.S.-trained physicians in the hospitals, wouldn't that be a positive development for some of these urban hospitals, and wouldn't that help the training programs in these hospitals because they would have better training and they would have a better quality of people that are attracted there?

Dr. GELLHORN. There is no question about it. But again, you have to redistribute quantitatively. The house officers are located in the major medical centers, which are increasingly becoming tertiary care centers. Bear that in mind. And if you give the responsibility either to the medical school, as you suggested—but as indicated by Dr. Heyssel, that is questionable, since the medical schools do not have much to do with GME—but let us say you give it, then, to the major medical centers. You are going to need some provision whereby the major medical centers assume the responsibility not only for the primary care training, but that they redistribute these house officers out into those exact hospitals that you have mentioned. And here is where your suggestion about affiliation is a possible way of doing it, but the affiliation has to be meaningful rather than nominal.

Senator QUAYLE. But even though we do it by affiliation, you would still have that determining factor being made at the State level rather than Federal.

Dr. GELLHORN. Yes. I do not think you can do it at the central level.

Senator QUAYLE. Fair enough. Senator Simon.

Senator SIMON. Dr. Asper, I noticed in reading your statement that you in fact have been the dean of the medical school at American University in Beirut, so you have looked at this thing from both sides. Of that medical school in Beirut, how many of the graduates stayed in the general Middle Eastern area and how many came to the United States?

Dr. ASPER. Well, Senator, the AUB is an unusual story. When I went there as dean in 1973, my goal was that all the graduates would serve the Middle East. In 1975, the fighting began, and an increasing number of graduates of the American University of Beirut have come to the United States and remained here, and some others have gone to other Middle East States to work, especially to Saudi Arabia.

There are, for example, today in the United States 60 psychiatrists who are graduates of the American University of Beirut, and yet the medical school in Beirut has no professor and chairman of the department of psychiatry.

So the emigration of these Lebanese physicians to the United States has been tremendous, and we have looked on those persons as being in a special category because of the upheaval in Lebanon.

But I think it is quite true that despite the current law, which says that foreign physicians who come here for study must go home again, there remain in this country a large number of foreign medical graduates who are here because they are refugees or

because they have already got permanent residency status for compassionate family reasons, and I think if they can be successful in getting ECFMG certification and entering a residency program, they will remain here.

I am not sure we have solved the emigration problem as yet.

Senator SIMON. As I look at table 1 that you have in your testimony, the foreign nationals who take the test here in the United States, using the 1983 figures number, 3,932. Do they stay in the United States, then? Am I correct in assuming that of the 19,850 who take the test, and 3,900 who pass the test, that that 3,900 stay here, and most of the other 15,000 or 16,000 go back to their country of origin?

Dr. ASPER. Well, the examination is given abroad as well as in the United States, so the FMG's may not have been in this country when they took the examination. But if a foreign national, having successfully passed ECFMG and received ECFMG certification then wants to enter a residency training program, under the former regulations that person also had to take and pass the Visa Qualifying Examination. Many foreign nationals took the ECFMG examination just to see if they came up to the American standard, and they have no intention of coming here for graduate study.

Senator SIMON. I see; and what is your guess, of that number of 3,900, how many actually——

Dr. ASPER. Could successfully pass the Visa Qualifying Examination or the new FMGEMS?

Senator SIMON. Yes.

Dr. ASPER. 2,400, sir.

Senator SIMON. So, we end up with 11 or 12 percent, in fact, coming in to practice in the United States, roughly—2,400 out of 19,000. I am not a great mathematician, but somewhere around 12, 13 percent.

Dr. ASPER. Yes, that is correct.

Senator SIMON. And then, Dr. Gellhorn—well, one other question to Dr. Asper. Do you feel—and you have been on both sides of this now—do you feel that of those 2,400—and, as it turns out, it is 2,400 U.S. citizens who take the test—do you feel comfortable about their practice of medicine in the United States?

Dr. ASPER. I feel comfortable only about their entering a residency training program and an accredited program—not licensure or practice, until they have been through the 3-year——

Senator SIMON. I understand, yes, OK. But you feel comfortable about their entering residency program.

Dr. ASPER. Yes, sir; they come up to the standard of graduates of U.S. schools in terms of their knowledge content of medicine.

Senator SIMON. And as I understand, you are now recognized through accreditation by all 50 States, your test; is that correct, or is that not correct?

Dr. ASPER. Yes, it is.

Senator SIMON. OK. Then—and I will address this question to you, Dr. Gellhorn, and maybe Dr. Asper would like to comment on it, too. In Illinois—and I have made a note to ask my staff to check this out—we used to have a dual system of accreditation. One was for general practice, and the second, for those who practice in mental hospitals in the State. Not that it was considered desirable,

but there was simply no way at that point that we were able to get physicians, probably because we did not pay them adequately—but it was a major problem for mental health service in the State of Illinois. I frankly do not know whether that is still the case, but I am checking that out.

Is that the case in New York; is that the case in other States, that you know of?

Dr. GELLHORN. No—well, I cannot speak to all other States. I think that the purpose, as you indicate, was to get some medical care into your mental health hospitals. In New York, we have at least an analagous situation, that the large proportion of physicians in our mental health institutions are foreign medical graduates, because it has not been possible to attract others.

Now, we have just begun to modify that by arranging that there will be an affiliation with one of the medical schools that will provide the medical services, just analagous to the VA situation. It will be an affiliation agreement whereby the medical services providing the house officers and students with invaluable experience with the problems of mentally ill patients, which at the moment, we as a society would prefer to disregard—get them out of the way and get them into the institutions.

But they are in more and more parts of our communities in the urban areas, and therefore, it becomes critically important that American, well-trained physicians understand about the problems and know how to treat them.

So we do not have at the moment a different sort of a test for those who are going in the mental health institutions, but it has been that the foreign medical graduates have been the ones who have peopled it.

Senator SIMON. Dr. Asper, do you know, does that exist elsewhere—or maybe you are just not aware of this.

Dr. ASPER. In many other States, the mental health hospitals are staffed almost entirely by foreign medical graduates and have been for a good many years, and many of the State health officers are quite concerned about this and are trying to correct the condition.

Senator SIMON. I have this concern, and it goes beyond the confidence of those who serve there. I have talked to patients in mental hospitals, and they will say, "I do not understand the doctor when he talks to me." And if there is one place where that understanding really is vital, it is in a mental hospital.

Finally, Dr. Gellhorn, you made an interesting suggestion, and that is that the commission should be a State-by-State commission rather than a national commission, and immediately, I have to say it had some appeal, because then you do not determine that if there is a need for "*x*" number of cardiologists, and they are all concentrating in New York, somehow, Illinois or Wyoming or some other place can also get served. But would there be pressure on—the University of Illinois to hold down the number of cardiologists—would Indiana University get the cardiologists and the training for cardiologists. Would the competition between States escalate those numbers?

Dr. GELLHORN. No, I do not think so. I think that again, there is going to have to be a Federal determination about the allocation of the resources on a State-by-State basis, and this may be done by a

whole variety of mechanisms, whether it be on a population basis, whether it be on antecedent experience modified by prospective experience. But then, within the State, the allocation of the support for graduate medical education should be determined by a State-functioning group rather than a national one. The problem, then, really puts it right back in your court for a determination of what is an equitable distribution of the available resources on a State-by-State basis. But I think that could be done.

Senator SIMON. Yes, Dr. Asper.

Dr. ASPER. Senator Simon, we have talked about the migration of physicians, a phenomenon that has been in existence for over 2,000 years throughout medical history, and the foreign medical graduates, both U.S. citizens and aliens. But what we have not addressed here is the migration of physicians within the United States of our own graduates, which is really quite a remarkable phenomenon. The State of Ohio, for example, produces far more physicians than it can use, and those graduates migrate to other parts of the country where physicians are needed, or where they think they have better opportunities or perhaps where the weather is a little bit better, such as California. And we really need, I think, to address sometime the migration of our own graduates within the United States.

Senator SIMON. I could not agree more, and not only within the country, but if I can use Ohio, my guess is Ohio has some of the same problems Indiana and Illinois do, that we have areas of great need that are not being served while physicians are going to California or to areas where the income is much greater.

Thank you, Mr. Chairman.

Senator QUAYLE. Thank you, Senator.

Gentlemen, thank you very much.

[The following responses were received for the record:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

National Institutes of Health
Building 31, Room 2B11
Bethesda, Maryland 20205

May 15, 1985

Ms. Mary McGrane
Legislative Assistant to
Senator Dan Quayle
Employment and Productivity Subcommittee
SD 428
Senate Office Building
Washington, D.C. 20510

Dear Ms. McGrane:

Enclosed are my responses to Senator Kennedy's questions regarding foreign medical schools.

Very sincerely,

Murray Grant, M.D., DPH
Chief Medical Advisor

Enclosures

From Senator Kennedy

QUESTIONS FOR MURRAY GRANT, M.D.

1. HAS THE FEASIBILITY OF ACCREDITING OFF-SHORE MEDICAL SCHOOLS BEEN EXPLORED BY AMERICAN ACCREDITING AUTHORITIES? ARE THERE ANY ACCREDITATION PROCEDURES IN COUNTRIES THAT HOST THESE MEDICAL SCHOOLS?

The Liaison Committee on Medical Education (LCME) approves and accredits U.S. and Canadian medical schools, including their clinical training programs. The LCME, has no authority for reviewing and approving other foreign medical schools or the clinical training programs provided in U.S. hospitals for U.S. citizens attending those foreign medical schools.

LCME has been asked to consider reviewing foreign medical schools to determine their comparability to U.S. schools. LCME declined this request. A number of medical organizations have advised GAO of the many problems involved in accrediting foreign medical schools including:

--The national and international political implications, and possible court actions that could result from nonaccreditation of certain schools.

--The large number of foreign medical schools which would make it difficult and costly to review schools in a timely manner.

We believe that many foreign medical schools, including many first-rate schools, would not seek accreditation because few of their graduates seek graduate medical education or licensure in the United States.

To our knowledge, there are generally no accreditation procedures for medical schools located in the off-shore countries.

QUESTIONS FOR MURRAY GRANT, M.D.

2. YOU HAVE MENTIONED THAT SOME STATES MAKE ADDITIONAL EFFORTS TO ASSESS THE QUALITY OF TRAINING RECEIVED IN FOREIGN MEDICAL SCHOOLS AND THE CORRESPONDING CLINICAL TRAINING IN DOMESTIC HOSPITALS. COULD YOU GIVE SOME EXAMPLES?

At the request of the Chairman, Subcommittee on Health and Long Term Care, House Select Committee on Aging, we are currently updating the States' efforts to assess the quality of training received in foreign medical schools. Upon issuance of our report, probably in late July, we will be happy to provide you with a copy.

3. WHICH ISSUES DO YOU FEEL MOST WARRANT FUTHER ATTENTION?

Our current study will address the issues that warrant further attention. Upon issuance of our report, probably in late July, we shall provide you with a copy.

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A. ☐ PHONE 215-386-5900 ☐ CABLE: EDCOUNCIL, PHILADELPHIA

March 28, 1985

The Honorable Dan Quayle
United States Senate
524 Hart Senate Office Building
Washington, D. C. 20510

Dear Senator Quayle:

It was indeed a privilege to testify on March 25 before the Subcommittee on Employment and Productivity Hearing on Graduate Medical Education. The roster of speakers was impressive, and I believe they presented a fair and accurate view on the issues you have raised.

I am enclosing a slightly modified copy of the backup document for my testimony. I would very much appreciate it if this corrected version could be included in the permanent record of the hearing, replacing what I sent to your office originally. Along with the backup document is a document marked "Spoken Testimony," which is a verbatim transcript of my talk before the committee.

In the question period, I was asked how many foreign medical graduate applicants apply yearly for ECFMG examination. In order to make the response completely accurate and to put the data in perspective, I should add the following:

For the February, 1984 ECFMG examination, there were 13,189 alien examinees and 5,026 U.S. citizen-examinees, for a total of 18,215 examinees. It is important to note that only 8,000 of these were taking the examination for the first time; 10,036 were repeaters. Of the examinees who took the combined medicine and English examination, the pass rate was 14.6% of all examinees (2,652). Of these, 1,175 were U.S. citizen foreign medical graduates and 1,477 were aliens. In other words, many apply and few are chosen.

With best wishes,

Sincerely yours,

Samuel P. Asper

Samuel P. Asper, M.D.
President

Enclosure

CC: Dr. Michael Whitcomb

ECFMG (WASHINGTON OFFICE) ☐ 2100 PENNSYLVANIA AVE., N.W., SUITE 738, WASHINGTON, D.C. 20037 ☐ PHONE 202 293-9320

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A. □ PHONE 215-386-5900 □ CABLE EDCOUNCIL, PHILADELPHIA

June 17, 1985

Ms. Mary McGrane
Legislative Assistant to
Senator Dan Quayle
Committee on Labor and Human Resources
Washington, D.C. 20510

Dear Ms. McGrane:

Enclosed are my responses to the additional questions from the Graduate Medical Education hearing of March 25, 1985 that were posed by Senators Hatch and Kennedy.

I do apologize for the delay.

Sincerely,

Samuel P. Asper, M.D.
President

Enclosure

ECFMG (WASHINGTON OFFICE) □ 2100 PENNSYLVANIA AVE., N.W., SUITE 738, WASHINGTON, D.C. 20037 □ PHONE 202 293-9320

FROM SENATOR KENNEDY

QUESTIONS FOR SAMUEL ASPER, M.D.

1. YOUR COMMENTS REGARDING OUR ABILITY AND PERHAPS RESPONSIBILITY TO TRAIN HIGHLY QUALIFIED PHYSICIANS FROM LESS MEDICALLY SOPHISTICATED PARTS OF THE WORLD ARE (1a) WELL TAKEN. WHAT IS YOUR FEELING REGARDING THE POTENTIAL DRAWBACK OF PROVING (1b) THIS TRAINING TO THE HOME COUNTRY, I.E., THE "BRAIN DRAIN?" (1c) COULD YOU ELABORATE ON ALTERNATIVE WAYS TO FINANCE THE EDUCATION OF ALIEN FOREIGN MEDICAL GRADUATES?

FROM SENATOR KENNEDY

QUESTIONS FOR SAMUEL ASPER, M.D.

2. YOU MENTION THE DIFFICULTY OF ACHIEVING PARITY BETWEEN THE NUMBER OF RESIDENCY POSITIONS AND THE SUPPLY OF LCME GRADUATES. WHAT DO YOU FEEL ARE THE OBSTACLES TO THE REDISTRIBUTION OF RESIDENTS FROM TEACHING HOSPITALS WHICH MAY BE OVER SUPPLIED WITH RESIDENTS TO COMMUNITY HOSPITALS UNABLE TO FILL THEIR PROGRAMS?

Senator Kennedy: Question 1a.

Senator Kennedy asks, "What... is the potential drawback of providing (graduate medical) training to the home country, i.e., the 'brain drain?'" If current immigration regulations are followed, there should be no significant loss of good physicians in the less developed countries. Qualified alien physicians can take residency positions here only for a period to complete specific courses of training. Moreover, there is good evidence that residency training in some hospitals in developing countries is improving. Accordingly, the demand of such training here may decrease somewhat in coming years.

It is recognized, however, that at present there are several thousand foreign-born graduates of foreign medical schools residing in the United States. Some hold refugee status, and many others have permanent residency permits and have already become U.S. citizens. These FMGs are most anxious to become ECFMG-certified, enter residency training programs and become licensed to practice. Some will be successful, others probably never. These uncertified, unlicensed "physicians" must gain their livelihood in the United States by engaging in work other than the practice of medicine. They do represent a medical brain drain from their countries, but they have chosen to live here.

More U.S. medical educators should work abroad in foreign medical schools. Such teachers have a tremendous impact on curriculum, on research and on patient care. They influence beneficially the lives of

many young foreign medical students and physicians. They also can identify those who would profit by further training in U.S. medical centers and often they can place young foreign physicians in good U.S. centers.

Question 1b

Senator Kennedy also asks about alternate methods of financing the graduate education of alien foreign medical graduates. There is no simple answer, no ideal solution, no plan that fits all alien FMGs who wish to study here and then return home. Here, however, are a few ideas:

(a) Encourage financing of travel and salary of the trainee by the home country or parent institution. Some developing countries already are willing to invest their limited resources in the training of specialists in much needed fields.

(b) Encourage financing of graduate education of alien foreign medical graduates by U.S. corporations that stand to benefit from the sale of medical equipment or pharmaceuticals overseas. For example, the modern day cardiologist requires sophisticated equipment and a variety of new pharmaceutical preparations to conduct a successful cardiology service for diagnosis and treatment of heart patients. Upon returning home, the foreign medical graduate who has studied cardiology in the United States is likely to purchase the U.S. equipment

and drugs with which he or she has become familiar. Accordingly, some U.S. manufacturers may consider the present training of foreign medical graduates to be a good investment for future sales.

(c) Encourage financial support of the training of alien FMGs by prosperous U.S. ethnic groups or organizations or by those immigrants to the United States who have achieved financial success and who continue to have warm ties to their native countries.

Question 2

Program directors are cognizant of the costs of graduate medical education. They will deny, I believe, that they are oversupplied with residents and will successfully defend the number of appointees to their services. Nonetheless, the distribution of residents among teaching hospitals is a tough issue. All accredited teaching programs are obligated to take the best of those who apply. And, since the qualifications for appointment of foreign medical graduates may not be as well known to program directors as those of U.S. medical graduates, foreign medical graduates often get the less desired positions.

At present, more than 2,000 accredited programs have no foreign medical graduates in training. I am confident that the position of the United States as a leader in international medical education would be

greatly enhanced if every year each of the 4,759 accredited U.S. programs took one FMG who will return home after training.

Finally, I believe that one of the potential obstacles to the fuller use of community hospitals as teaching institutions for residents may be the lack of infrastructure in the community hospitals for an integrated approach to teaching, research and service.

QUESTIONS FROM SENATOR HATCH: DR. SAMUEL ASPEN

I AM INTERESTED IN SEVERAL ASPECTS OF TRAINING FOR "FMG's". COULD YOU ANSWER QUESTIONS 1 AND 2 ACCORDING TO THREE CATEGORIES:

1) U.S. CITIZEN, FMG
2) ALIEN FMG TRAINING IN THE U.S.
3) ALIEN UMSG

1) WHAT PERCENTAGE OF F.M.G.'S BECOME BOARD CERTIFIED BY ONE OF THE AMERICAN BOARDS OF MEDICAL SPECIALTIES?

2) WHAT PERCENTAGE OF FMG'S BECOME PRIMARY CARE PHYSICIANS? WHAT PERCENTAGE OF THOSE WHO STAY IN THIS COUNTRY PRACTICE IN FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS?

3) DO YOU HAVE DATA ON HOW MANY U.S. MEDICAL SCHOOL GRADUATES LEAVE THIS COUNTRY TO WORK AS PHYSICIANS, FOR AN EXTENDED PERIOD (I.E. GREATER THAN THREE MONTHS) ABROAD?

This is in response to the three questions of Senator Hatch. He requests that answers to his questions 1 and 2 include three categories: USFMGs, alien FMGs, and alien USMGs.

There are limited data on alien students studying in the 127 accredited U.S. medical schools. In 1983, of 70,800 students enrolled in all U.S. medical schools, 354 (0.5%) were foreign nationals. Thus, their number is small. I know of no analysis of the citizenship of aliens in U.S. medical schools, their reasons for seeking entry into a U.S. medical school, their subsequent performance on specialty board examinations, or the number who enter primary care, either in the U.S. or abroad. Accordingly, in replying to questions 1 and 2, the third category is omitted.

1) What percentage of FMGs become board certified by one of the American boards of medical specialties?

In 1982 it was estimated that approximately 41,000 (38%) of 107,000 foreign medical graduates in the United States were certified by a specialty board.[1] For purposes of comparison, 264,652 (52.7%) of all 501,958 licensed physicians (graduates of U.S. and foreign schools) in the United States were certified in a specialty.

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[1]Personal communication from Mr. John Loft, American Medical Association, to Ms. Sally Oesterling, ECFMG, on March 1, 1985.

Only recently have some specialty boards initiated studies of the performance of both alien and U.S.-citizen FMGs on specialty examinations. In particular, the American Board of Internal Medicine (3624 Market Street, Philadelphia, PA 19104) will likely have data for release in a few months.

2) What percentage of FMGs become primary care physicians? What percentage of those who stay in this country practice in federally designated medically underserved areas?

In 1982, the latest year for which data are available, foreign medical graduates comprised 21.4 percent of the total licensed physician population and also of the total number of physicians in patient care in the United States.

Within the FMG population of 107,284, 87,524 physicians (81.6%) were in patient care, and over two-thirds (58,892 or 67.3%) were in office-based practices. While many physicians in office-based practices are specialists (e.g. dermatologists, rheumatologists, psychiatrists, etc.), it has been shown repeatedly that most specialists spend about 40-50% of their practice as primary care physicians. For example, the cardiologist caring for a cardiac patient continues to care for the patient when other illness, such as influenza, strikes.

In 1982, of 87,524 licensed alien and U.S.-citizen FMGs, 16,459 (18.8%) were in internal medicine, 10,596 (12.1%) in general

practice, and 8,140 (9.3%) in pediatrics (8,140). These are the specialties that render most of the primary care.[2]

I do not have data on the number of FMGs working in federally designated medically underserved areas.

3) Do you have data on how many U.S. medical school graduates leave this country to work as physicians for an extended period (i.e. greater than three months) abroad?

Officials of the National Council for International Health estimate that 8,700 U.S. medical and other health professionals are working in international health-- 46% long-term employed, 33% short-term volunteers and 20% short-term employed. Of this total number, approximately 1,400 are physicians, 637 of whom are long-term, 309 short-term, and 471 volunteers[3]. Thus, less than 0.4% of all U.S. physicians are engaged in international work. Reportedly, there are 241 budgeted vacancies in international health for physicians. The majority of the vacancies are for volunteers (128) and for long-term employees (88).[4] Timothy D. Baker, M.D., M.P.H. of Johns

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[2]American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 edition. Chicago: American Medical Association, pp. 39, 52.

[3]Baker, T.D., Weisman, C. and Piwoz, E., "United States Health Professionals in International Health Work," American Journal of Public Health, vol. 74, no. 5, (May, 1984), pp. 438-431.

[4]"MDs urged to be involved in world health," American Medical News, February 3, 1984.

Hopkins University School of Hygiene and Public Health, has compared the involvement of U.S. health professionals in international settings with that of Cuba where a population one-twentieth the size of the United States provides almost one-fourth as many health professionals to international health activities as the United States.[5] [6]

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[5]Baker, T.D., Weisman, C. and Piwoz, E. " U.S. Physicians in International Health," Journal of the American Medical Association, vol. 251, no. 4, January 27, 1984, p. 504.

[6]Grundy, P.H., and Budetti, P.P. "The Distribution and Supply of Cuban Medical Personnel in Third World Countries," American Journal of Public Health, vol. 70, no. 7, July 1980, pp. 717-719.

cialties. However, care must be exercised in the interpretation of the specialty data displayed in this table, which is the *only table* in this publication that presents the entire list of 82 specialties. For all other tables in this volume, the list of 82 specialties is aggregated into the more generalized specialty categories. For example, the aggregation of specialties into a general category is displayed in Table B-2 in the specialty of Internal Medicine, which shows a total physician count of 79,980. In Table B-8 the Internal Medicine count of 79,980 is distributed among the subcategories of Allergy and Immunology (850), Diabetes (417), Endocrinology (2,093), Geriatrics (714), Hematology (2,076), Infectious Diseases (1,672), Immunology (359), Internal Medicine (64,151), Neoplastic Diseases (657), Nephrology (2,558), Nutrition (182), Oncology (2,334), and Rheumatology (1,917). The *List of Designated Specialties* in the Appendix Section presents the grouping of the detailed 82 specialties into the general specialty categories used throughout this publication.

The TEN specialties showing highest counts of physicians in 1982, given the category explanations above, included: Internal Medicine (64,151), Family Practice (33,831), General Surgery (32,135), Pediatrics (29,687), General Practice (28,508), Psychiatry (28,467), Obstetrics/Gynecology (26,409), Anesthesiology (18,794), Orthopedic Surgery (15,571), and Ophthalmology (13,841). Proportionate percentages of residents in these specialties demonstrated the following distribution: Internal Medicine (28.8%), General Surgery (26.8%), Pediatrics (19.9%), Family Practice (17%), Orthopedic Surgery (15.9%), Anesthesiology and Obstetrics/Gynecology (15.8%) each, Psychiatry (13.7%), and Ophthalmology (10.1%).

Foreign Medical Graduates

Activity by Specialty

In 1982, foreign medical graduates (FMGs) accounted for 21.4 percent of both the total physician population and total physicians in Patient Care (Table B-9 and Table 1). Within the FMG population itself, 81.6 percent physicians were in Patient Care. Of this group of 87,524 physicians, over two-thirds (67.3%) were in Office Based practice, representing nearly 20 percent of all Office Based physicians in the U.S. and Possessions (19.7%). FMGs accounted for approximately 19 percent (18.7%) of all physicians in residency training and nearly 40 percent of all Hospital Based full-time physician staff (38.9%). One-fourth of all physicians in Research (25.6%) and one-out-of-five physicians in Medical Teaching were FMGs (18.8%). Only 12.5 percent of all physicians in Administration were graduates of foreign medical schools.

More than 60 percent of all FMGs were in the specialties of: Internal Medicine (16,459), General Practice (10,596), Pediatrics (8,140), Psychiatry (7,890), General Surgery (7,819), Anesthesiology (7,008), Obstetrics/Gynecology (6,188), and Pathology (4,461). Nearly 40 percent (38.3%) of all FMGs in residency training were concentrated in the Medical specialties while 32.7% were in Other Specialties. The Surgical specialties comprisod approximately one-fourth of all FMG residents (23.8%) while General Practice did so at only 5.2 percent.

Activity by Age and Sex

Nearly twice as many FMGs (Table B-10) were in the 35-44 age group in 1982 (38.2%) than in the under 35 group (18.9%). Women FMGs comprised 19.5 percent of the FMG complement. Age distribution for women FMGs indicated the highest percentage in the 35-44 group (44.3%) followed by 23.9 percent under 35. Over one-third of male FMGs (36.7%) were 35-44 while approximately one-sixth (17.7%) were in the under 35 group. Figure 7 illustrates the distribution of total FMGs by age and activity.

FIGURE 7 – FOREIGN MEDICAL GRADUATES BY AGE AND MAJOR PROFESSIONAL ACTIVITY, DECEMBER 31, 1982

Source: Table B-10

Reference 2

TABLE B-10 — FOREIGN MEDICAL GRADUATES BY AGE, ACTIVITY AND SEX
December 31, 1982

Activity	Total	AGE GROUPS: Under 35	35-44	45-54	55-64	65 and Over
			BOTH SEXES			
Total Physicians	107,284	20,254	40,976	25,189	12,576	8,289
Patient Care	87,524					
Office Based	58,092	6,690	23,836	16,341	8,266	3,759
Hospital Based	28,632					
Residents	12,088	9,188	3,050	578	72	
Full-Time Staff	15,744	1,547	6,629	4,572	2,283	713
Other Prof. Activity	6,103					
Administration	1,680	46	358	578	474	224
Medical Teaching	1,410	164	546	400	217	83
Medical Research	4,286	1,169	1,827	730	375	185
Other	727	66	239	193	114	115
Inactive	4,052	165	459	370	390	2,668
Not Classified	6,106	1,190	3,405	965	254	292
Address Unknown	1,499	29	627	462	131	250
			MALE			
Total Physicians	86,323	15,246	31,690	21,346	10,841	7,200
Patient Care						
Office Based	49,741	5,212	19,395	14,383	7,355	3,396
Hospital Based						
Residents	9,545	6,974	2,128	391	52	
Full-Time Staff	11,870	1,048	4,738	3,608	1,853	623
Other Prof. Activity						
Administration	1,375	35	267	485	408	200
Medical Teaching	1,129	121	409	346	182	71
Medical Research	3,542	922	1,491	630	329	170
Other	519	34	165	150	92	78
Inactive	2,820	42	123	195	249	2,211
Not Classified	4,575	839	2,497	778	211	250
Address Unknown	1,207	19	517	380	110	181
			FEMALE			
Total Physicians	20,961	5,008	9,286	3,843	1,735	1,089
Patient Care						
Office Based	9,151	1,478	4,441	1,958	911	363
Hospital Based						
Residents	3,343	2,214	922	187	20	
Full-Time Staff	3,874	499	1,891	964	430	90
Other Prof. Activity						
Administration	305	11	111	93	66	24
Medical Teaching	281	43	137	54	35	12
Medical Research	744	247	336	100	46	15
Other	208	32	94	43	22	17
Inactive	1,232	123	336	175	141	457
Not Classified	1,531	351	908	187	43	42
Address Unknown	292	10	110	82	21	69

Reference 3

United States Health Professionals in International Health Work

TIMOTHY D. BAKER, MD, MPH, CAROL WEISMAN, PhD, AND ELLEN PIWOZ, MHS

Abstract: This article reports results of a survey of 1,257 potential employers of US health professionals overseas, interviews with informants in international health, an analysis of career patterns of a small group of international health workers, and a review of numbers of health professionals trained in schools of public health for international health work. There are approximately 9,000 US health professionals in the international health field. Doctors (1,400), nurses (1,500) and administrators (900) are the largest groups. Church-related agencies (2,200 people), private voluntary agencies (1,700 people), and universities (1,000 people) are the largest employers. (*Am J Public Health* 1984; 74:438-441.)

Introduction

United States health professionals have held important roles in international health for over seven decades.[1-10] To plan careers, US health professionals need to know which organizations employ what types of health professionals overseas, future staffing needs, the types and numbers of US health professionals available, and the resources for training for international health work.

In 1981, documentation of numbers of US personnel engaged in international health was fragmentary and outdated. The Johns Hopkins University School of Hygene and Public Health, Department of International Health, had surveyed international health agencies in 1969,[8] but no more recent information existed. This study updates the 1969 report and discusses implications.

Study Design and Methodology

Our definition of international health was simple and comprehensive: "Any health activity undertaken between governments or people from two or more nations." Thus, it included such widely differing types of work as: World Health Organization disease control programs, clinical services provided by medical missions and corporations, research overseas by US universities, and population and nutrition activities associated with health programs.

Organization Survey

The survey of organizations consisted of a self-administered, four-page, pretested questionnaire[11] mailed to 1,257 US and international organizations with possible international health activities and personnel. The list of organizations was compiled from: The National Council for International Health (NCIH) mailing list; the 1969 survey list of US Government and international agencies; all Schools of Public Health; and a list of 354 US companies with international interests screened for companies most likely to employ US health professionals. Follow-up phone calls were made to clarify responses.

The response rate was 55 per cent overall. A random sample of approximately 10 per cent of the 569 non-respondents was selected and all were contacted by phone to ascertain the degree of response bias and to provide an estimate of numbers of US health professionals working for non-respondent organizations.

Respondents to the original survey were twice as likely to have international health activities and use US personnel as nonrespondent organizations. We have corrected the total figures in Table 1 to include estimates of US health professionals working for non-respondent organizations. Detailed data are based on initial questionnaire responses only, and not on our non-respondent sample.

To estimate completeness of our survey, we checked the numbers of all US physicians in the American Medical Association Directory[12] with foreign, or APO addresses as an independent source. We assumed minimal under-reporting of long-term assignments based on US studies of completeness[13,14] of the AMA physician directory. However, short-term assignments would not be picked up.

By concentrating on employing institutions and firms, we have underestimated unaffiliated, self-employed US health professionals in international health.

Other Sources of Information

Additional information was compiled through a survey of informants hiring and training US health professionals in international health, and an examination of training programs in US Schools of Public Health. The career patterns of health professionals trained in Schools of Public Health were also examined.

Informants contacted were interviewed personally.[15] Included were personnel from the US Agency for International Development (AID), the US Army, Navy, and Peace Corps, the World Bank, the Pan American Health Organization, consulting firms, health care corporations, and faculty from Schools of Public Health. Course catalogues (1981) from all US Schools of Public Health were reviewed for information on international health courses and programs.

We estimated the number of years spent in international health by all 66 US students graduating from the Department of International Health at Johns Hopkins University during its first 10 years (1962–1971).

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[1]Gorrah ME, Baker TD, Conyngham RB. International Health—United States Involvement. Presented at the Annual Meeting, Association of Schools of Public Health, Washington, DC, April 6–8, 1970. (Available from School of Hygene and Public Health, Johns Hopkins University, Department of International Health, Baltimore, MD 21205.

Address reprint requests to Timothy D. Baker, MD, MPH, Professor, Department of International Health, Johns Hopkins University, School of Hygene and Public Health, 615 N. Wolfe Street, Baltimore, MD 21205. Dr. Weisman is Associate Professor, Department of Behavioral Sciences, and Ms. Piwoz is Research Assistant, Department of International Health, both at JHU SHPH. This article, submitted to the Journal May 16, 1983, was revised and accepted for publication December 16, 1983.
Editor's Note: See also related editorial p 430 this issue.

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TABLE 1—US Health Professionals Working in International Health

Occupational Type	Long-term Employees	Short-term Employees	Volunteers	Total	Per Cent
Physicians	837	309	471	1,617	22
Nurses	849	183	646	1,488	23
Dentists	131	31	218	380	6
Social Workers	53	25	100	178	3
Health Educators	109	97	43	248	4
Pharmacists	43	9	33	84	1
Nutritionists	48	72	60	180	3
Technicians (laboratory, X-ray, etc.)	86	9	54	149	2
Allied Health Personnel	38	8	79	125	2
Environmental Health	115	72	50	237	4
Health and Hospital Administrators, Managers, Planners	481	366	178	881	14
Health Manpower Trainers/Educators*	196	137	137	430	7
Other**	430	82	125	642	10
TOTAL	2,980 (48%)	1,308 (20%)	2,151 (33%)	6,439	
Corrected Totals***	3,800	1,700	3,200	8,700	

*Excluding MDs, nurses, and other health professionals.
**Including estimate from non-respondent organizations.
***Public health advisors, social scientists, researchers, students, and many unclassified.

Results

Table 1 shows the numbers of US personnel by occupational category working for the 281 reporting organizations. It also shows corrected grand totals including estimates from the non-respondent sample and the World Health Organization's uncategorized workers. Detailed figures do not reflect the numbers of health professionals working for non-respondent organizations as the 10 per cent sample was too small for a breakdown by occupation.

There are at least 8,700 health professionals (3,800 long-term, 1,700 short-term, and 3,200 volunteers) working in international health.**

The largest category of personnel is nurses, the second, physicians, and the third, health and hospital administrators, managers, and planners. About 45 per cent of both physicians and nurses and 54 per cent of administrators are long-term employees.

One-half of the physicians and one-third of the nurses were engaged in clinical (medical care) work; one-third of both nurses and physicians were engaged in public health. The remainder were in other types of work such as administration and teaching. Approximately one-half of the long-term "other" employees were reported by the Agency for International Development.

The AMA Directories showed 1,840 MDs overseas compared to our estimated survey figure of 1,880 MDs (actual number reported, and estimated number of MDs from non-reporting agencies). Since temporary address changes are not shown in the directory, our survey has underestimated short-term MD assignments.

Approximately 700 vacancies were reported; 47 per cent long-term, 14 per cent short-term, and 38 per cent volunteer positions.

Professionals by Type of Organizations

Table 2 shows employing groups of health professionals. One-third of all personnel reported are classified as "volunteers" (private voluntary organizations) such as CARE/MEDICO, Intermed, Project Concern, HOPE, etc.; church-related organizations report the greatest number of volunteers. The volunteers in government organizations are primarily from the Peace Corps. Only 20 per cent of all personnel are reported as "short-term employees." Almost half of all reported personnel are long-term employees. Private voluntary organizations (PVOs) employ the smallest proportion (29 per cent) of long-term employees.

Surprisingly, endowed foundations (included with PVOs) represent only 3.5 per cent (n = 14) of all organizations reporting international health activities and employ only 38 US health professionals. The past impact of the foundations on international health has been much greater than their present small numbers of personnel would indicate.

Compared to the average for all organizations combined, physicians and nurses are overrepresented in church-related organizations; nurses are underrepresented in universities; and, physicians are underrepresented in governmental agencies. Health and hospital administrators, managers, and planners are concentrated in corporations and businesses; environmental health specialists are concentrated in PVOs, corporations, and businesses. Most health educators and training personnel work for PVOs and related organizations.††

Other Surveys

Most informants felt that the expansion of opportunities for US health professionals in international health of the past decade would not continue. Opinions ranged from guarded optimism that the present levels of employment would continue for the next five years with improved opportunities

**Long-term employee*. A salaried person employed either full-time or part-time for a period of one year or more. *Short-term employee*. A salaried person employed either full- or part-time for less than one year (e.g., most consultants). Full-time employees who spend less than 50 per cent of their time in international health work are coded as short-term employees. *Volunteer*. A non-salaries person who may, however, receive a stipend, transportation costs, subsistence, or living allowance.

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TABLE 2—Health Professionals by Responding Organizations (NOTE:* estimates from non-respondents not included)

Type of Organization (No. of Organizations)	Types of Workers			Total Number of Personnel*	
	Long-term Employees	Short-term Employees	Volunteers		
					%
Church-related (62)	1,221	81	887	2,189	33
Private Voluntary Organizations, etc. (62)	479	357	833	1,669	15
Universities (67)	500	387	98	985	15
Corporations, Businesses (31)	488	410	13	679#	13
Government Agencies (9)	336	73	310	867**	13
All Organizations (261)	2,980	1,308	2,152	6,387**	99

*Health personnel unidentified by type, but included in totals (most are long-term).
#The estimate from phone call follow-up that 300 more health professionals were employed by this category of employers.

over the following five years, to pessimism that present job opportunities would actually decline. Opinions were based on the assumptions that major sources of federal support for international health would dry up under the budget reduction policies of the Reagan Administration and the reluctance of recipient nations to hire expatriates.

No informants experienced difficulty in recruitment of health professionals with the exception of public health physicians. Many stated that language capability was an essential factor in hiring. The majority felt that special training in international health was a major asset.

Sources of information on current job opportunities available to the US health professionals seeking overseas employment include the National Council for International Health Directory,[17] "Action,"[18] and Job Bulletins from many Schools of Public Health.

There was consensus that the first job assignment overseas was the most difficult one to secure. Most informants felt that many US health professionals would have to take a volunteer or almost-volunteer position for the first assignment. Over the next five-year period high-level, full-time, consultant positions would be most available in institution building or training.

The informants from training institutions said almost uniformly that they had more applicants than they could admit to the classes and that they had difficulty in finding positions for graduates.

Table 3, based on information compiled by the Association of Schools of Public Health, 1976–1979, displays the approximate number of persons training for international health work (less than 3 per cent of all applicants and graduates). Definitions of "concentration in international health" vary from school to school. Also, many persons now working in international health have not had formal public health training. Therefore, caution should be used in interpreting these figures.

The survey of graduates from the first 10 years of operation (1962–1971) of Johns Hopkins University Department of International Health projects an average working time of about 12 years in international health. Of the 66 graduates, nine (14 per cent) are following lifetime careers in international health, 18 per cent did not enter international health, 42 per cent spent five years or less in international health activities, and 27 per cent left international health for US work, but later returned to international health. The sample is not representative of the universe of US health professionals in international health and assumptions are made concerning continuance in international health after completion of training in international health.

The supply for US health professionals currently employed in international health may be measured by a survey of employers, but the pool of job-seekers and the potential supply is hard to ascertain as US health professionals move in and out of international health, training requirements are variable, and the field is very diverse.

Discussion

The demand for US health professionals in international health depends on: the "pull" from receptor nations and the "push" from the US. The "pull" from receptor nations comes from the need for additional hands to provide direct services, the desire for new technologies, and the desire for external, uncommitted consultants. The "push" factor comes from US/foreign policy purposes, US universities' research interests, church-related proselytizing interests, and commercial firms profit interests. Motivation of US health professionals includes idealism, opportunities for adventure, research opportunities, chances for learning about new cultures, and, in a few cases, higher earnings.

In the future, if the US Government moves away from international involvement in health, and recipient countries are less interested in using expatriate health professionals, the demand for US health professionals seems likely to level off from the expansion of the last decade.

To place the demand in perspective, less than 1 per cent of US health professionals[19] are engaged in international health work, a stark contrast to the 13 per cent of Cuban physicians working in overseas assignments.[18,19]

TABLE 3—Applicants, Students, and Graduates in International Health in US Schools of Public Health*

International Health	1976–1977	1977–1978	1978–1979
Applicants			
US	101	170	161
Total, including foreign	167	252	305
Graduates			
US	38	36	56
Total, including foreign	56	63	87

*Compiled from International Reports and Executive Summaries (1976–1979), Association of Schools of Public Health.

At present, the major source of training for international health workers is Schools of Public Health. Although a number of medical colleges had an interest in training for international health work in the late 1960s and early 1970s, most official training programs have been terminated. There are few independent training programs in international health in nursing, hospital administration, or dental schools.

The large numbers of short-term workers, clinical workers, and volunteers indicate a major need for short courses, primarily self-instructional, available at any time of the year, preferably in several different geographic locations. It is unrealistic to expect short-term workers, volunteers, and most clinicians to take a full course in international work to prepare for an assignment that is either short in duration or primarily clinical in nature. This need for short courses was noted in the first Hopkins study of US Health Professionals in 1969 (footnoted earlier).

The relatively large number of long-term health professionals in international health who are not engaged in patient care (over 3,000***) points up the need for long-term training, such as is available in Schools of Public Health.

Most US health professionals in international health do not follow lifetime careers. Using our estimated average work life of roughly 12 years after completion of training in international health, approximately 250 US health professionals each year would benefit from specialized international health training to replace those currently in the workforce (long-term, non-medical care health professionals, divided by average working years). The existing programs in Schools of Public Health have adequate facilities to expand to meet expected demand for international health training.

Our survey shows an increase of 63 per cent in US health professionals working in international health since the survey undertaken 12 years ago. Most of the increase is real, but a part results from a more extensive survey. All informants we consulted agreed that most of the increase in numbers in the past 12 years was real, however.

Although church-related organizations still employ the largest number of full-time employees, PVOs, businesses and universities have rapidly expanded their hiring in the past decade. Governmental and quasi-governmental agencies have decreased in relative and absolute importance compared to a decade ago. Each of the other groups employs roughly one-half the number employed by churches.

The reason for the apparent shift of corporations and PVOs to greater importance as employers of US health professionals in international health are twofold: the development of a new and growing market in the Arabian Gulf nations for US health professionals; and the rapid increase in numbers of small consulting firms. The second area of growth appears now to have come to a close. Several firms have made mergers, while others are leaving the international health field. The major changes between our 1969 survey and the current survey indicate the need for regular reappraisals of US health professionals working in international health.

In summary, international health work offers widely varying opportunities for a relatively small number of US health professionals. Past contributions of Americans in international health have had major importance to world health. Further contributions will depend as much on levels of financing of international health programs and collaborating mechanisms for projects as on the training and dedication of the US health professional.

***Corrected total, less corrected number of clinical (medical care) personnel.

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Freudenberg, environmental groups perceive health departments as "evasive," "reluctant," "obstructive," and given to "covering up," health officials may very well see environmental groups, or at least some of them, as unwilling to accept complicated explanations, suspicious, closed-minded, and occasionally motivated by narrow self-interest and even political aspiration.

And while Freudenberg depicts environmental groups as frustrated by the seemingly perverse way health professionals viewed certain environmental risks, it would come as no surprise were public health officials to report high levels of frustration as they encounter relentless pressures for the commitment of scarce resources to combat ill-defined, environmental hazards, but little popular enthusiasm for taking aim against the proven and terrible hazards of smoking, alcoholism, poor diet, lack of exercise, and failure to simply buckle up in the family car.

The clamor over environmental issues is testing the public health official as never before. As public servant, he must respond to the needs of the people and be sensitive to the political world with which he deals, and in which he must survive if he is to do any good, as physicians, engineer or scientist. The incomplete state of our knowledge must not serve as an excuse for failure to take prudent action. Public health has never clung to the principle that complete knowledge about a potential health hazard is a prerequisite for action. Quite the contrary, the historical record shows that public health's finest hours often occurred when vigorous preventive action preceded the crossing of every scientific "t" and the dotting of every epidemiological "i".

However, the temptation to be responsive and to minimize conflict with environmental groups at *all* costs must be resisted. The public health official cannot afford to barter scientific integrity for good opinion and peaceful public relations. To the virtues of patience, openness, and humility recommended by Freudenberg, public health workers must also bring fortitude and an unwavering allegiance to the pursuit of truth and the rigorous application of the scientific method. They must somehow rise above the clamor, and demand the solid evidence on which sound public policy must be founded. They must somehow find the strength in the face of criticism and false accusations to continue to be the voices of reason and to help keep our health priorities straight.

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International Health: Academic Specialty or Humanitarian Service?

In this issue of the Journal the article on "US Health Professionals in International Health" by Baker, *et al.*[1] is very timely because there is a growing awareness of the great need for the United States to collaborate in improving health conditions in the developing world. The very recent Report of the National Bipartisan Commission on Central America[2] describes this need for only one region of this troubled world. That report makes it very clear that political stability and security for any country depend as much on redressing and improving the social conditions of the war, revolution, and terror-torn populations, as it does on military imposed law and order.

Among the social conditions which have to be changed, better health care is one of the most, if not the most, important and desired by all the people. More effective, affordable, and egalitarian curative, preventive, and rehabilitative care for individuals and families must be established. Well organized public health services much reach everybody in the population. This—together with identical efforts in the field of education—is crucial if nations wish to preserve the social structure under which they choose to live. A much greater effort of US health professionals and educators is absolutely necessary, if only to begin to achieve improvements. Not only must we help to build and rebuild facilities and organizations, we must also assist in training and retraining health care providers and teachers. Let us not quibble about whether this is done more effectively by supporting institutions and programs in the developing world or by bringing individuals from developing countries to US institutions. Both types of educational and training activities are indicated under appropriate conditions, as long as the training institutions engage in this effort in a serious, sustained, and unselfish way. International activities cannot and should not be undertaken solely because they can bring financial gains to the training institutions. One of the major reasons for "foreign assistance" should be recognized as altruistic. Humanitarian considerations by the more affluent societies should lead to some sharing of wealth, skills, knowledge, and consequently also of health manpower. The article by Baker, *et al*, demonstrates that this sharing indeed takes place. As a matter of fact, the figures given tend to underestimate the true involvement of the US health care community in international cooperation (as it should be called rather than assistance). Perhaps the main difficulty in correctly estimating the true extent of international activities undertaken by US health workers is created by the fact that there is no real international health career pattern in this country, in the sense that such a career existed (and to some degree still exists) in the colonial powers who have had vast overseas administrative responsibilities. There is no specialty of "International Medicine" any more than "Rural Medicine," "California Medicine," or "Africa Medicine." The "International" indicates the site, the environment, in which a primary care physician, nurse, dentist, health services administrator, or any other health worker provides services. The fact that a health professional school does not have a "Department of International Health" does not exclude the possibility that virtually thousands of foreign health personnel are being trained in clinical and non-clinical fields relevant to work abroad, or that such school does not have an active health program abroad. It is even possible that a separate Department of International Health might convey

to other departments the impression that international concerns are not their responsibility and thereby have a negative effect on the overall international involvement of the institution as a whole. Strong participation of many departments with the coordination by an office or an individual responsible for the international aspects might be most desirable. In point of fact, very few of the 127 medical schools in the US have "Departments of International Health" yet the vast majority of them do have international programs. I would argue that this is healthy and that equal concern for the underserved and underprivileged in the US and abroad should be fostered by our educational institutions. One should accept that international health does not know boundaries and therefore includes attention to health conditions everywhere. Indeed it has been my experience that students, who witnessed and worked in poverty areas in the third world, upon return to the US showed a much greater understanding for the problem of poverty at home. For these reasons one should applaud the mixture of domestic and foreign activities in which, according to Baker, *et al*, the majority of graduates of Johns Hopkins University's Department of International Health engaged.

This opinion that International Medicine is not a specialty, and *should* be integrated into the various programs of the institutions, obviously should not be used to defend the deplorable decrease in training programs for activities abroad. These opportunities for health workers to prepare themselves for work in other countries—aiming at the specific and diverse medical, social, cultural and political conditions—should be increased and improved both at the under- and postgraduate levels. The effectiveness of our activities depends as much on our overall understanding of our foreign collaborators and their society, as on technical skills.

And this is the main reason why the health professional schools will have to play such an important role. Not only are they the major source of manpower, whether it be for their own projects or indirectly for recruitment by agencies, commercial firms, or voluntary organizations, but also the logical site for training and development of educational programs and materials.

For an academic institution to embark in international work, the project must be scientifically and technically sound, offer learning opportunities for faculty and students, and, where possible, allow research activities. Only under rare conditions can a US academic institution be expected to participate significantly in the financing of the assistance component. It should be prepared, however, to fund the research and teaching activities of faculty and students abroad. On the other hand, a US academic institution should not expect to realize a profit from activities in the developing world any more than it would expect to profit from a similar socially significant project at home.

The role of the academic institution should be one of learning, teaching, and providing service to the needy at home and abroad.

Dieter Koch-Weser, MD, PhD

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Nursing Research Abstracts Sought

Abstracts of research on clinical practice applications of nursing theory are being sought by the School of Nursing at the State University of New York at Buffalo which will sponsor, on May 3, 1985, a conference titled "Clinical Applications of Nursing Theory: Developing a Professional Knowledge Base through Research."

Nursing professionals from throughout the country are invited to send their abstracts by September 3, 1984 to Marietta Stanton, PhD, RN, Continuing Nurse Education, State University of New York at Buffalo, Hayes Annex D, 3435 Main Street, Buffalo, NY 14214.

Abstracts should be typed, double-spaced, approximately 400 to 800 words long, accompanied by curriculum vitae.

More information can be obtained by calling 716/831-3291.

Introductory Epidemiology Course Offered at U-VA

A short course on "The Principals and Applications of Epidemiology" will be conducted June 7–8, 1984 at the Medical Center, University of Virginia School of Medicine, Charlottesville, VA. The deadline for registration is May 23; fee $50. CEU credits (1.5) have been applied for.

This course is intended for professionals and students with an interest but no prior training in epidemiology. The course will cover basic quantitative principals of epidemiology and the spectrum of problems to which these principals apply. Emphasis will also be placed on the interpretation and evaluation of epidemiologic research.

For information, contact: Amy C. Sharpe, Epidemiology Short Course Coordinator, U-VA Medical Center, Box 473, Charlottesville, VA 22908, tel: 804/924-5159 or 924-2777.

Reference 4

American Medical
NEWS

FEBRUARY 3, 1984

MDs urged to be involved in world health

There are political as well as humanitarian reasons for greater commitment to international health by American physicians, say researchers in a recent issue of the *Journal of the American Medical Association*.

"For example, Cuba, with less than one-twentieth the population of the United States, provides almost one-fourth as many health professionals to international health activities as the United States," say Timothy D. Baker, MD, MPH, and colleagues from Johns Hopkins U. in Baltimore. "The political ramifications of this imbalance are obvious."

Adds JAMA Editor George D. Lundberg, MD: "Our balance of payments of physicians in this country is heavily positive with a ratio of almost 50 to one of physicians having immigrated vs. those sent from here abroad. . . . We as a profession should cultivate a mind set that looks to all humanity.

"The medical profession itself, academic institutions, foundations, industry, churches, and government should re-emphasize this concept of medical internationalism. . . . Turnabout is fair play," Dr. Lundberg says.

THE JOHNS HOPKINS researchers, in cooperation with the National Council for International Health, conducted a survey of organizations to determine both the numbers of physicians working in international health and the demand for additional numbers indicated by budgeted vacancies.

"We estimate that 8,700 U.S. health professionals are working in international health — 46% long-term, 33% volunteers, and 20% short-term employed," they say.

"There are 241 budgeted vacancies in international health for physicians, the largest number of vacancies for any professional group," they add. The majority of the vacancies are for volunteers (128) and for long-term employes (88).

FROM 1969 TO 1981, "government agencies have decreased in importance as employers of U.S. health professionals overseas," the researchers comment. "Church-related organizations still employ the largest number of health professionals, but private voluntary organizations, corporations, and universities have almost caught up."

In a related report, William V. Dolan, MD, OFM, a Franciscan friar, tells of "an intermittent elective surgery service in direct support of a rural primary care program in the Central Amazon Valley of Brazil." The relatively sophisticated surgical subspecialties bring needed curative treatment and also serve as a lure for preventive and public health measures, including immunizations, he adds.

Reference 5

US Physicians in International Health

Report of a Current Survey

Timothy D. Baker, MD, MPH; Carol Weisman, PhD; Ellen Piwoz, MHS

• Little is known about the magnitude and specifics of current involvement of US physicians in international health. This report presents results of a survey of 1,257 organizations with interests in international health work and discusses career opportunities and needed training for US physicians in international health.

(JAMA 1984;251:902-904)

THE ROLE of US physicians in foreign countries deserves the same attention as has been given to foreign physicians in the United States.[1] The current and future supply and demand for US physicians in international health are not well known. Professional associations and medical educators need this information for planning and policymaking.

The American Medical Association and its members have been active in international health activities from World War II to the present.[2] The AMA helped establish the World Medical Association and supported the work of the World Health Organization and the International Refugee Organization. In the past decade, the AMA Volunteer Physicians for Vietnam Program[3] (Ira Singer, PhD, oral communication, August 1982) made it possible for almost 1,000 US physicians to serve in a troubled part of the world. The AMA was a major force in the establishment of the National Council for International Health (NCIH), which provides a forum to help coordinate the international health activities of more than 1,000 US institutions. The AMA's activities complement extensive earlier contributions of American physicians to international health.

In disease control and eradication, American physicians such as Walter Reed, William Gorgas, Fred Soper, and Max Teiler elucidated the chain of transmission of yellow fever, instituted measures to control the urban cycle, and developed an effective vaccine to mitigate the effects of jungle yellow fever.[4] American physicians were largely responsible for the development of the current technique of oral rehydration therapy to combat infant diarrhea, the major cause of death in much of the underdeveloped world.[5] Two US physicians, Dr William Foege of the Centers for Disease Control and Dr D. A. Henderson, working for the WHO, deserve much of the credit for the success of the world's first program to eradicate a disease—smallpox.[6]

In addition to the programs of disease control, US physicians have been active in institution building. Peking Union Medical College, with an initial staff of US physicians, trained a generation of the leaders in medical education in China. The Vellore Christian Medical College performed a similar function in India. United States physicians have also served as visiting faculty in many other foreign medical schools and schools of public health.

With this rich heritage of past contributions in international health, what are the opportunities for US physicians overseas today?

Few physicians, even in policymaking positions, know the answers to the following questions. How many US physicians are currently working in international health? For what types of organizations do they work? What percentage of all US physicians are involved in international health? The following study was carried out to answer these questions.

METHODS

The Johns Hopkins University Department of International Health (JHU/DIH) and the NCIH conducted a survey of organizations to determine the numbers of physicians and other health personnel working in international health, their types of work, and the demand for additional personnel as reflected in budgeted vacancies. The organizations surveyed

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The statements in this report are those of the authors and not necessarily concurred in by the Agency for International Development.

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Table 1.—US Health Professionals in International Health*

Occupational Type	Long-Term Employees	Short-Term Employees	Volunteers	Total (%)
Physicians				
Clinical	340	69	356	665
Public health	172	187	58	417
Other	185	50	180	341
Total	937	306	471	1,417 (22)
Nurses†	340	100	340	1,480 (23)
Health and hospital administrators, managers, planners (excluding MDs and RNs)	481	260	158	881 (14)
All Other	1,313	841	856	2,980 (41)
Total	2,980 (46%)	1,306 (20%)	2,181 (33%)	6,430
Corrected Totals	5,600	1,700	3,800	6,700

*Personnel currently working for 261 organizations responding to the survey and corrected totals for nonrespondents. All are US citizens working abroad or in the United States on international health activities. For definitions of types of workers, see text.

were drawn from NCIH's mailing list, a JHU/DIH 1969 survey of international health agencies, and a list of 354 US corporations with international health personnel. In total, 1,257 organizations were listed and surveyed.

The four-page questionnaire to the organizations was developed and pretested at JHU/DIH (for details refer to the report to the US Agency for International Development).[1] After an initial and follow-up mailing of the questionnaire in the fall of 1981, a 55% response rate was attained. While this is an acceptable response rate for an organizational survey, response bias in the survey was ascertained by a 10% random sample of nonresponding organizations contacted by telephone. Nonrespondents were only half as likely as responding organizations to have current international health activities. Based on our sample of nonresponding organizations using US health personnel, the numbers of personnel from responding organizations were adjusted to reflect better the total numbers of US health personnel in international health activities. (Current AMA directories were reviewed to determine the approximate number of US physicians with overseas or APO addresses as a check on the completeness of our survey.)

In addition to the major survey of organizations, 20 key informants from training institutions and governmental, international, commercial, and religious organizations were surveyed. Another substudy reviewed subsequent work in international health of all 66 US graduates from the JHU/DIH's first ten years of operation (1962 through 1971) to determine the average working life of US health professionals in international health. The training capacity in international health in the US schools of public health was studied.

RESULTS

This brief report deals primarily with physicians, but information on nurses, hospital and health administrators, managers and planners, and all other US health professionals is included as a base of comparison. The full report[1] with details on other professions and sample questionnaires is on file with the Office of Health, US Agency for International Development (the sponsoring organization), JHU/DIH, and the NCIH.

We estimate that 6,700 US health professionals are working in international health—46% long-term, 33% volunteers, and 20% short-term employees. Long-term employees are salaried employees, full- or part-time, working for one year or more. Short-term employees are full- or part-time, working less than a year. Volunteers are nonsalaried but may receive transportation costs, subsistence, or a living allowance.

Table 1 shows physicians and nurses are the major categories of health professionals engaged in international work. The "other" category included trainers and educators, 7%; dentists, 6%; environmental health specialists, 4%; health educators, 4%; social workers, 3%; nutritionists, 3%; technicians, 2%; allied health personnel, 2%; and pharmacists, 1%. More than half of the long-term physicians are engaged in clinical practice, most working for church-related projects or profit-making corporations. The priority given to public health by international agencies is shown by the large number (almost one third) of physicians working in public health. (In the United States, only 1% of physicians work in public health.[2])

Approximately one third of all physicians in international health volunteer their services. Most volunteers are clinicians, reflecting the relative ease in finding short-term, unpaid clinical assignments.

There are 241 budgeted vacancies in international health for physicians, the largest number of vacancies for any professional group. The majority of these vacancies are for volunteers (128) and for long-term employees (88). Of the long-term vacancies, two thirds are for clinical physicians. Estimates of vacancies are far less precise than the number of workers reported.

Our survey of 66 graduates from the JHU/DIH first decade to determine the attrition rate of MDs in international health showed that the average age of graduates was 33 years and that they worked an average of 11.6 years in international health. Of the 66 graduates, nine followed lifetime careers in international work, 12 did not enter the field, 28 spent five years or less, and 18 followed a mixed pattern of both international and national work. (We assumed that graduates who worked in international health from the time of graduation to the present would continue working until retirement age of 65 years.)

COMMENT

Changes From 1969 to 1981

In comparison with a 1969 study carried out by the JHU/DIH,[3] the current survey shows an increase of 63% in US health professionals working overseas.

During this period, governmental agencies have decreased in importance as employers of US health professionals overseas. Church-related organizations still employ the largest number of health professionals, but private voluntary organizations, corporations, and universities have almost caught up. The reason for increased importance of US corporations is primarily the market for US health manpower in the oil-rich nations. Among private voluntary organizations, the rapid increase of small consulting firms working for the US government has been a major

Table 2.—US Physicians and Nurses in International Health as Percent of Total US Physicians and Nurses

	No. in International Health	Total No. of US* Professionals	% of Total US Health Professionals
Physicians	1,417	450,000	.32
Nurses	1,488	1,300,000	.12

*Health US 1980. Department of Health and Human Services publication No. PHS 81-1232. Hyattsville, Md, 1980. (Based on Census and National Center for Health Statistics data). Projected to 1981.

factor.

Despite the increase in US health professionals working overseas, other countries have had relatively greater increases. For example, Cuba, with less than one twentieth the population of the United States, provides almost one fourth as many health professionals to international health activities as the United States. The political ramifications of this imbalance are obvious.

Training

The large number of physicians (>1,400) who are serving overseas as clinicians or volunteers or in short-term assignments indicate a major need to develop short courses to orient physicians in international health. Such courses should be primarily self-instructional and available at any time of the year in several US locations.

On the other hand, training for physicians and other high-level health professionals for long-term, nonclinical assignments in international health requires a more intensive, longer program. Such programs are currently available in some schools of public health. Recent data on graduates from training programs in international health indicate that there are too few fully prepared US health professionals for the estimated job openings requiring new or replacement personnel each year.[7] (Average international health graduates per year [42] times average years of work after graduation [12] equals future supply of international health workers [516]. Estimated future demand for high-level international health workers equals 1,500.)

US Physicians in International Health in Perspective

While their absolute numbers are large, Table 2 shows that less than half of 1% of all US physicians are engaged in international work.

Thus, past criticisms that US involvement in international health constitutes a drain on the US physician supply are not valid. Rather, there are real opportunities for US physicians to participate in international activities serving both humanitarian and personal goals.

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Reference 6

Public Health Briefs

The Distribution and Supply of Cuban Medical Personnel in Third World Countries

PAUL H. GRUNDY, MD, MPH, AND PETER P. BUDETTI, MD, JD

Abstract: More than 2,000 Cuban health care personnel are presently providing care in third world nations. less than five years ago this number was fewer than 100. Some 1,500 of these are physicians, representing nearly 13 per cent of Cuba's 12,000 health service physicians. Cuba dominates the health care delivery system of four small African nations and South Yemen, and Cubans are a major presence in a number of larger countries, such as Iraq. (*Am J Public Health* 1980; 70:717-719.)

Soon after the revolution in Cuba, the government chose to develop the health care delivery system as a model of the benefits to be expected under the leadership of Fidel Castro. Spending nearly 15 per cent of their national budget on health care and social welfare delivery, the Cubans have achieved a health status profile comparable to those of more developed countries.[1-3] Having made major progress at home,[4,5] the Cubans are eager to export their physician-oriented health care system to developing countries.

In recent years the number of Cuban health care personnel working abroad has grown dramatically. In 1976, the government officially reported 492 health care professionals living abroad, of which 280 were physicians.[6] By 1977, these figures were 795 and 437, respectively.[7]

Our figures for 1978 (Table 1), obtained directly from the Ministry of Health in Havana and supplemented and confirmed when possible from published sources, reveal that the total number of Cuban medical personnel overseas is over 2,300. This is probably an underestimate, since our data on Iraq, Angola, Ethiopia, Jamaica, and Laos include only physicians. The number of medical doctors totals approximately 1,500, meaning that nearly 13 per cent of Cuba's 12,000 national health service physicians are now overseas.

Cuba began to export health care personnel in 1963, sending a health care delegation to Algeria, which at the time was engaged in a border conflict with Morocco. Health care personnel have remained in Algeria since that time and presently include 17 physicians, most of whom teach in the clinical subspecialties.[7] In the intervening years, Algeria has greatly increased its own physician supply, so that Cubans now constitute less than one per cent of the total number of physicians.

In neighboring Libya, on the other hand, Cuba has an estimated 650 medical personnel who provide the great bulk of health care in that country. Iraq is another country in which Cuba has a large contingency of health personnel, 378 as of September 1978.

Cuba supplies almost the entire health care delivery system to four small African nations and to South Yemen, on the Arabian peninsula. In the Cape Verde Islands, there are 81 Cuban medical personnel; approximately 44 of the 62 physicians in the country are Cubans. Guinea-Bissau has 55 Cuban medical personnel; at least one-half of the country's physicians are Cubans. In Sao Tome, the 86 Cuban medical personnel include about 80 per cent of that country's physicians. Equatorial Guinea has 48 Cuban health professionals, including 26 of the country's 31 physicians.

In Ethiopia, Cuba's military presence is complemented by the presence of 300 physicians caring for the Ethiopian civilian population.[8] These physicians make up nearly one-half of the physician population in Ethiopia. Since Ethiopia already had a medical school at Addis Ababa and a core of medical professionals, the Cuban approach in Ethiopia has been to form joint teams of health care professionals.

From the Health Policy Program, School of Medicine, University of California, San Francisco. Address reprint requests to Dr. Peter P. Budetti, Director, Washington Office, Health Policy Program, University of California, 2233 Wisconsin Avenue, NW, Suite 535, Washington, DC 20007. Dr. Grundy, former medical student, University of California at San Francisco, is on active duty with the United States Air Force, South Korea. This paper, submitted to the Journal November 26, 1979, was revised and accepted for publication March 3, 1980.

Editor's Note: See also related editorial, p. 681, this issue.

TABLE 1—Distribution of Cuban Health Care Personnel Working Abroad

Third World Country	Number of Cuban Health Care Personnel*	Number of Cuban Physicians*	Total Number of Physicians** (1977)	Percentage of Cuban to Total Physicians	Population in Millions***	Population per Physician
Iraq	378	208	4500	4 6	12 5	2.778
South Yemen	84	58	98	57 0	1 8	18.367
Algeria	17	11	1888	6	17 8	10.388
Benin	8	‡	95	‡	3 3	34.737
Cape Verde	81	44	62	71 0	32	5.161
Angola	286	286	383	75 0	6 4	16.710
Congo	31	17	213	8 0	1 5	7.042
Equatorial Guinea	48	26	31	84 0	33	10.645
Guinea	73	41	188	22 0	5 1	27.127
Guinea-Bissau	55	30	55	55 0	82	11.273
Libya	650	357	2588	14 0	2 9	1.083
Mozambique	120	67	510	13 0	9 9	19.412
Ethiopia	‡	300	874	45 0	31 9	47.329
Sao Tome	86	47	59	80 0	084	1.434
Tanzania	15	8	797	1 0	16 8	21.079
Zambia	18	11	472	2 3	5 4	11.441
Guyana	18	18	120	15 0	81	6.750
Jamaica	17†	17	570	3 0	2 2	3.860
Laos	12†	12	46	26 0	3 5	76.087
Vietnam	‡	‡	‡	‡	51 1	‡

SOURCES: *See text.
**World Health Statistics Annual 1977. Volume 3. Health Personnel and Hospital Establishments (ISBN 9240677736). World Health Organization. Geneva, Switzerland. 1978.
***Prohist IV. World Population Estimates 1978. Washington, DC: The Environmental Fund. 1978.
†Number unknown.

Cuba has had two African failures. In Somalia, Cuba was faced with war between leftist Somalia and more leftist Ethiopia, and was asked to remove all its delegation. Sierra Leone's President, Dr. Siaka P. Stephens, told one of the authors (PG) that he asked Cuba to remove its two medical personnel in 1977, but Cuban officials denied having had medical personnel in Sierra Leone when asked about the incident.

In South Yemen, Cuban involvement has evolved from providing nearly the entire health care delivery system to the point where Cubans are now building the country's first medical school in Aden. The country's 98 medical doctors are now more or less evenly divided into two categories: specialists teaching in the university, and physicians providing primary care.

Cuba has the following numbers of medical personnel in four non-African countries in addition to South Yemen: Guyana 18,[10] Laos 12, Jamaica 17, and Vietnam (number unknown). The 17 Cuban physicians in Jamaica were readmitted after being asked to leave in mid-1977 following a medical malpractice incident. Cuba and Vietnam have an agreement to send Cuban medical personnel to Vietnam and also to train Vietnamese physicians in Cuba.[3] The Cuban government has not released any official report of the number of medical personnel who have been assigned under that agreement.

Even in the very poor African nations, Cuba's approach to health care delivery is very much along the lines of the physician dominated polyclinic model. Each polyclinic is staffed by primary care physicians who specialize in internal medicine, pediatrics, and obstetrics and gynecology.[4, 5, 11] Nurses and other professionals play a secondary role in this system, as the present official Cuban policy completely rejects both family practitioners and non-physician practitioners. At first, the entire health care team—both physicians and ancillary personnel—was comprised of Cubans. More recently, Cuba's policy has been to train native ancillary health personnel. This policy will allow Cuba to focus its efforts on supplying additional physicians to expand the number of clinic sites.

The physician's service abroad is generally for one or two years, with pay comparable to that of the native physicians in the country in which they are stationed. The physician's family remains in Cuba and continues to receive the full salary that the doctor would have earned in the domestic medical service. This is an important factor since Cuban physicians' salaries are significantly higher than those of most other workers, and physicians have a relatively high standard of living.[4]

Conclusion

In less than five years, the number of Cuban medical personnel working abroad has increased from less than 100 to more than 2,000. Because Cuba is a socialist state with strong ties to the Soviet Union, and has openly provided military support to "national liberation" movements in Africa, many in the United States question the purportedly humanitarian motivation behind Cuba's medical foreign policy.

Many of the countries in which Cuban medical personnel are working, however, are clearly in need of such help. Until the United States is ready to share its medical resources on a large scale, many countries of the third world are likely to continue to accept such help from our small southern neighbor.

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STATE OF NEW YORK DEPARTMENT OF HEALTH
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DAVID AXELROD, M.D.
Commissioner

May 9, 1985

Ms. Mary McGrane
Office of Senator Dan Quayle
Senate Office Building
Washington, DC 20510

Dear Ms. McGrane:

The enclosed is in response to your letter of May 2, 1985 requesting answers to questions put by Senator Kennedy. Should there be additional information which I can provide, please let me know.

Sincerely,

Alfred Gellhorn

Alfred Gellhorn, M.D.
Director of Medical Affairs

enc.

In response to Senator Kennedy's questions;

I. What are the factors that have caused such a large percentage of residency positions in New York and New Jersey to be filled with foreign medical graduates?

Answer: a) New York City has the largest accumulation of medical schools (7) and associated medical center hospitals of any city in the country. New York City also has the largest number of municipal hospitals (17) in the country as well as a large number of non-profit hospitals in the five boroughs and immediate suburbs. Eighty percent of all the residency positions are concentrated in New York City.

b) Since the number of residency positions is far in excess of the number of New York medical graduates and since the proportion of New York graduates leaving the state for training elsewhere is just balanced by the medical school graduates from other states who come to New York for their residency training, the gap is filled by foreign medical graduates. At the present time, the latter constitute almost one-third of all the residents in the state.

c) All of the residencies, whether filled by U.S. or foreign medical school graduates, have been approved by the appropriate residency review committees. Since, to date, 40 percent of the direct and indirect costs of graduate medical education are funded by Medicare and the remainder, in New York, by Medicaid, the Blues and private insurance, there has been no incentive on the part of hospitals or individual medical services to curtail the number of residency positions. In fact, since the salary for residents now range from $25,000 to $30,000 per annum and the residents average a 60 hour work week, the hospitals are delighted to have cheap, skilled labor at no cost. This accounts for the number of positions which continue to grow despite a decrease in hospital beds! Once again, the vacuum created by an insufficient number of U.S. medical school graduates for the available residency spots is filled by FMGs. In the main, these are in inner city hospitals, state hospitals, and small community hospitals.

d) A final factor which is applicable to both New York and New Jersey is that the greatest number of U.S. citizens, those who have failed to gain admission to U.S. medical schools, seek their medical degree from foreign medical schools. Increasingly, these schools are located in Mexico and the Caribbean, are proprietary institutions created for the U.S. tuition dollar, and, in general, are substandard as measured by the performance of their graduates on standard tests.

As to New Jersey, I cannot speak authoritatively, but I believe that the major problem is the poor quality of the residency programs which therefore fail to compete successfully for U.S. medical school graduates.

II. What mechanisms do you feel would be workable to redistribute qualified medical school graduates to teaching hospitals with a preponderance of foreign medical graduates?

Answer: a) Either by mandate or by incentives, integrated residency programs between community hospitals and the major medical centers or otherwise lead-hospital must be established. In New York where this occurs the adverse environment of inner city does not prevent having an essentially complete complement of U.S. medical school graduates.

b) If we are to train young physicians more appropriately for comprehensive, continuous, personal care with emphasis on disease prevention and health promotion, it will be necessary to increase training in ambulatory settings. At the present time, too much of graduate medical education emphasizes high technology, tertiary care. The salary for residents which is tied to reimbursement for in-patient care perpetuates a situation which is generally recognized to be counterproductive for the training of doctors who can keep us out of the hospital as much as possible.

c) The number of residency positions should be reduced. If the Medicare support for graduate medical education is to be provided by a block grant to each state, the amount could be calculated by the number of medical school graduates in the state plus 20 percent. This would allow for the influx of U.S. medical school graduates from other states in excess of the number of graduates in a particular state and also not prevent highly qualified foreign medical school graduates such as political emigres and others from obtaining necessary training.

Alternatively, if the funding is to continue to go to to each hospital, it could be restricted to those programs with no more than 25 percent of foreign medical school graduates. In New York, this would sharply reduce the number of residency programs. If correlated with the first suggestion (a) above) to require integrated residencies, it would assure better quality of training and patient care as well as reduction in the overall residency positions.

Sentor QUAYLE. Our next witness is Dr. Robert Graham, Administrator of Health Resources and Services Administration, go ahead and proceed.

STATEMENT OF DR. ROBERT GRAHAM, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, ACCOMPANIED BY DR. ITZHAK JACOBY, FORMER STAFF DIRECTOR OF GRADUATE MEDICAL EDUCATION, NATIONAL ADVISORY COMMITTEE

Dr. GRAHAM. Thank you very much, Mr. Chairman.

I would like first to introduce Dr. Itzhak Jacoby, who is accompanying me. Dr. Jacoby spent 5 years with the Graduate Medical Education National Advisory Committee during the time that it was in operation. He is now a member of the staff of the National Institutes of Health. But, as you may have questions this morning that relate to GMENAC, either Dr. Jacoby or I would be happy to respond.

We have prepared and submitted to you for the record a lengthy opening statement. I will not read that. I would simply like to summarize as an overview the message of that statement.

I feel that the discussions that you have embarked upon this morning are both timely and important. As you pointed out in your opening statement, it has been about 10 years since the U.S. Congress looked at the issues of U.S. manpower supply and distribution within the medical profession. In that 10 years, a number of changes have taken place—changes within the educational system, undergraduate and graduate; changes within the distribution of medical providers in the United States, and increasingly, changes in the way that health services are being provided throughout the system. I think with that degree of change and with that degree of flux in the system, it is very appropriate to take a look at where we are right now and what our desirable end points may be.

There are several principles that I think are important to be considered for any change in the graduate medical education.

First, I would emphasize primary care, and that is primary care at the exit point of graduate education, rather than the entry point.

Second, I would emphasize that all graduates of certified, accredited U.S. medical schools have an opportunity to pursue graduate education. It makes no sense to provide persons with an M.D. or D.O. degree and then not provide them with an opportunity to practice their profession.

Third, whatever transitions may be desirable or necessary, we need to have time to make those transitions in an orderly sense. Whether it is in response to some of the proposals the chairman has made or others, it is going to be necessary to redistribute both human and dollar resources, and that transition cannot be accomplished in 6 or 12 months.

And finally, I think it is necessary to establish a fair base for compensation for graduate education. Whatever our feeling is about the distribution, the level of graduate education we should have in the country, we need to acknowledge that this is a function which is important to the overall health system and that some fair

basis of compensation to support those entities which are carrying out that education and those who are participating in it needs to be established.

Now, I have deliberately tried not to respond to any of the specifics, Mr. Chairman, of your proposal, to any of the GMENAC report, or to any of the comments of the prior witnesses. Either Dr. Jacoby or I, in the time remaining, would be happy to pursue whatever line of discussion either of you would like.

Senator QUAYLE. OK, thank you very much, Dr. Graham.

Do you agree that it is necessary to have some sort of mechanism in place that is going to shift the distribution of physicians in this country from that of too many in specialty care toward primary care?

Dr. GRAHAM. Let me respond to that by giving you a disclaimer, and it is a disclaimer which will bear on most of the rest of my discussion this morning. I am responding as an individual in the context of the responsibilities that I have at the present. I will not necessarily be sharing with you the point of view of the Department, because we are still looking at the proposals, and, at an appropriate time, will inform you and the Congress of what our position may be on specific proposals.

Senator QUAYLE. Yes, I think the record should be very clear on that point, that you are going to be speaking as an individual, that this is not an administration position, but you, as Dr. Graham. Sometimes we find that more refreshing than if you would have to be up here, reflecting a certain opinion that had already been reached.

So, fair enough.

Dr. GRAHAM. Given the conversations I have been involved in on appropriations, I find it very refreshing, also. [Laughter.]

I would have to fairly characterize myself as a wide-eyed fanatic about primary care. My background is in family practice. No system can function effectively or usefully at the extreme. I would never say that primary care should be expanded at the expense of subspecialty care.

The issues that you are leading us into are very complex issues, and unfortunately, I think, cannot be addressed just by looking at the distribution of graduate training within the supply of medical professionals, because quite frankly, I also believe we are heading into a profound oversupply of medical professionals. We are going to have to deal with the issue of specialty distribution, but within a finite supply of M.D./D.O. professionals within the United States. Yes, I believe that we do not presently have an adequate supply or an adequate proportion of individuals trained in primary care, and it is appropriate to look at mechanisms which might increase that proportion.

Senator QUAYLE. OK. I agree with your statement that whatever procedure we develop, mechanism, et cetera, will have to have a smooth transition period, and I think that that is well-stated and a point well worth commenting on.

Have you given—and maybe this is too much detail—have you given any thought to what kind of a burden you feel it would be on hospitals, in particular, if we would ask them to be formally affiliated with a medical school, whereas about 80 to 90 percent of them

are, but on a voluntary basis? From your viewpoint, do you find this to be intrusive to a degree that would become somewhat burdensome?

Dr. GRAHAM. It might be, and it might not be.

Senator QUAYLE. How about modeled after the VA relationship that they have with teaching hospitals—are you familiar with that?

Dr. GRAHAM. I am, and that is why I gave you something of an ambivalent response to begin with. To determine whether or not an affiliation agreement would be burdensome or intrusive, I think, necessitates a definition of the teeth that that affiliation agreement has. If that is an exchange of polite letters, then it is probably not burdensome. If the agreement is to subsume under the decision-making umbrella of the medical school some control of the behavior of those teaching hospitals in the distribution of their graduate education, then that might be intrusive.

I think part of the concern I would reflect in the direction that you go is that it seems to me the logic behind the general proposal you have made thus far is you are seeking to find a point of accountability.

We have a very pluralistic system right now where the medical schools have one type of accountability in the educational context, and the various entities which were outlined to you before have responsibility for graduate education.

If you try to move greater accountability into the medical school sector, you will move away from some of the strength in the non-tertiary care, or nonmedical school hospital sector right now, which indeed is primary care. In one sense, if you look at the profile of where primary care graduate education is taking place today, and look at the profile of "tightly affiliated" university hospitals, you would be putting more responsibility on the university system, which has a lower profile of primary care than the other. You might be moving in the opposite direction on the continuum that you want.

So, what is an affiliation agreement to mean? When you ask is affiliation burdensome or intrusive, I have to say maybe yes, maybe no.

Senator QUAYLE. But using the VA model as a standard, is that a reasonable approach?

Dr. GRAHAM. My understanding of the VA agreements that exist between most of the hospitals and the medical schools is that they are specific to a degree in terms of resources, sharing resources, faculty appointments, reimbursement, that is greater than the degree of affiliation that exists between many primary care residency programs and medical schools at the present time.

Is that a better model? What do you want to accomplish? If you want to accomplish greater accountability in the medical schools, yes, that might be a useful model to look at.

Is it a better model to cause the flowering of primary care programs? It may not be.

Senator QUAYLE. Going back to the point that you said what we are trying to achieve is precisely the case. And that is a focal point of reference so we can get some sort of accountability on the over-

all direction of primary care. There is absolutely no thought whatsoever to get into detailed specification on specialties.

Dr. Jacoby, you were the Staff Director of GMENAC. I wonder if you might give us an update on that report. There have been some questions about the methodology that was used there—your particular findings and the relevancy of those findings, and how it applies today, if you would.

Dr. JACOBY. Yes. Let me just mention that I left the field of manpower very close to the time of submission of the report, so I have been in the periphery, of the field since 1981. But let me review the reaction to the GMENAC findings and related comments.

As far as consensus validity is concerned, when we presented the results and concluded that the country was heading toward an 8-percent increase in the general population and a 35-percent increase in the number of physicians per 100,000 people, it was clear that such an increase in physicians would present a problem.

In other words, even if GMENAC calculation of physician supply or requirements were in error by a few percent, the overall conclusion projecting an 8-percent increase in the number of people and a 35-percent increase in the number of physicians had a rather broad consensus validity.

As far as the detailed studies, there was very little debate around the physician supply models. These are well-accepted actuarial models. Since GMENAC did its calculations, the model has been exercised again, with more recent data. Indications are that GMENAC projections for 1990 might have erred by about 1 or 1½ percent on the high side, basically because GMENAC assumed continuous growth in medical school entrants for a few years, whereas the actual enrollment stabilized rather quickly after GMENAC. The overall impact on physician supply of this change seems to have been only 1 to 1½ percent.

There was much more controversy around the physician requirements model or estimation process. GMENAC used a group process to look at all the data. This process is not new; the first investigators to use such an approach was Lee and Jones in 1933. And it is a widely used method to obtain opinion and expert judgment from a group when empirical evidence is not available.

The numbers obtain reflected the views of the groups we convened. They were rather broad-based groups that included academicians and practicing physicians from both urban and rural areas. They provided us with their judgment on the data, from which we derived the requirements.

One study has attempted to look at these requirements estimates against what is going on in what Dr. Relman referred to as a closed goods systems and the conclusion was that GMENAC overestimated physician requirements by about 25 percent.

Senator QUAYLE. Senator Simon?

Senator SIMON. Yes. We have two distribution problems. One is within the profession. And I share your prejudice on—obviously, if we share it, it is an objective analysis, rather than prejudiced—toward the need for greater primary health care.

The second is the geographical distribution of where people serve. And since you are here, and you direct the Health Resources and Services Administration, I notice on page 3 of your testimony,

you talk about $100 million in new guarantees for private loans; $67 million will be available through revolving funds, but those loans stimulate us to have a system where the well-to-do serve the well-to-do, rather than responding to the areas of greatest need for health care in our country.

The National Health Service Corps is zeroed out in the budget. Is that really where we ought to be going?

Dr. GRAHAM. A complicated question. I believe that we have the ability in the coming decade to improve the geographic distribution of our practitioners by a number of means which may not call heavily upon the programs that you have just cited.

We have had the experience, quite honestly, over the last 5 years, of seeing a profound difference in the distribution even of primary care providers within the United States, so that it has been necessary for us to totally revalidate all of our shortage area designations and redesignate a large number of areas, and to change the strategy by which we assign National Health Service Corps individuals. That is because we find people in practice privately now, or in groups, in locations where they were not to be found 5 and 7 years ago—in inner city and rural sites.

We believe, based upon our best data and estimates, that there will continue to be areas of underserved populations in the United States in the 1990's. There will be two basic reasons for underservice, as near as we can tell. One will be geographic isolation. I come from Kansas. There are cities and towns in Kansas, which had doctors around the turn of the century that may never have a doctor again, and that is because there are 250 to 300 people, they have a market area of 1,200. We just cannot find a 20th century trained physician who is willing or should establish a practices in communities like that. But that certainly is a factor in Kansas, at least, that keeps driving the perception that we still have a shortage of physicians.

Geographic isolation is going to be one area where we will continue to have some maldistribution.

The other reasons for underservice, though, particularly as you start talking about the dynamics of inner-city service, has to do with what appears to us to be financial barriers to care. That gets into a whole different set of issues of how we pay for services, who pays for services, what the local role is versus the Federal role. But we are finding in our assignment patterns in the National Health Service Corps, that if it is possible for us to provide grant funds to Community Health Centers in the inner cities, they are telling us they are perfectly comfortable using those funds to go out on the street and advertise and hire physicians privately from within the community or accept one of our obligors in their practice; that they have applicants now where they did not have them 7 years ago.

In 1984, we had 500,000 practicing physicians in the United States. In 2000, about 15 years from now, we will have 700,000 practicing physicians in the United States. At whatever level we are right now, we are going to increase that level by 40 percent. I would never argue to you that that is going to take care of all of the problems of distribution just by trickledown, but major elements of the problem that we have been dealing with in the last 20 years do appear to be responding to the pressures for new practice

opportunities as these new graduates seek out someplace to go when they finish off their residency program.

For that reason, I must say, having struggled with the administrative difficulties of the National Health Service Corps Scholarship Program, which gives you a 7- or 8-year time line between the time somebody signs up for their obligation and the time they are ready to go and provide service, I do not think that is a very effective way to obligate people for public service. And if we are to continue with that program, we have made the proposal, which is being discussed within the Department and within the administration now, that the scholarship program at some point be replaced with a loan forgiveness program, so if there are to be public funds obligated to get practitioners into areas where they are needed, we do that at a time when that practitioner is fully competent, fully trained, and is willing to make that commitment, and we do not have this 5 to 10 to 15 percent of what is essentially a bad debt problem that we have right now, with people who signed up in 1977, then when 1984 comes around, says, "Not convenient. I won't go."

Senator SIMON. And if I understand you, what you are saying is that you are considering a loan forgiveness program, so that if a physician will go into Cairo, IL, which is underserved, that that physician then could get that loan forgiven.

Dr. GRAHAM. Yes.

Senator SIMON. Well, whether it is a loan forgiveness program or National Health Service Corps, how we do it, it just seems to me it is imperative that we do it. And I would appreciate anything you can do to push that along.

Dr. GRAHAM. Well, we are presently in discussions with OMB about that proposal, because the National Health Service Corps still has two more large scholarship classes to come out of the pipeline. I would not anticipate that the proposal would be submitted for discussion in the Congress for another year or so. But that is the avenue that we are tending toward if there is a consensus between the administration and the Congress that it is appropriate for us to continue to have publicly obligated providers, that that obligation mechanism is far better a loan forgiveness mechanism than a scholarship mechanism.

Senator SIMON. Dr. Jacoby, just one question. You are working where at NIH now?

Dr. JACOBY. I was working with the Graduate Medical Education National Advisory Committee in what was then the Health Resources Administration, part of Dr. Graham's agency. Now, I am at NIH, in the Office of the Director, and I am doing very little work related to physician manpower.

Senator SIMON. Thank you both very much.

Senator QUAYLE. Gentlemen, thank you very much.

[The prepared statement of Dr. Graham and responses to questions submitted by Senator Kennedy follow:]

STATEMENT BY

ROBERT GRAHAM, M.D.

ADMINISTRATOR, HEALTH RESOURCES

AND SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

MARCH 25, 1985

Mr. Chairman and Members of the Subcommittee:

I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. I am pleased to have the opportunity to appear before you to discuss various questions relating to graduate medical education and the Public Health Service's role with respect to physician supply and specialty distribution. I am accompanied today by Dr. Itzhak Jacoby, formerly director of the Office of Graduate Medical Education, Health Resources Administration and now with the National Institutes of Health.

In my testimony, I shall describe briefly the Health Resources and Services Administration's activities relating to graduate medical education. At your request, I shall make particular reference to the extent to which these activities have been responsive to the

recommendations of the Graduate Medical Education National Advisory Committee, as set forth in the Committee's report to the Secretary of the Department of Health and Human Services in September 1980. I should like also to make a few comments from my own perspective on your recent proposal for reform of the system of Federal funding for graduate medical education, described in the Congressional Record for January 31, 1985.

Mr. Chairman, may I emphasize at the outset that my remarks will be based on two assumptions. The first assumption is that non-Federal organizations and groups -- educational institutions, health care facilities, professional associations, accrediting bodies, and State and local governments, among others -- will continue to provide leadership in developing and maintaining our complex system of advanced clinical training of physicians. The Federal Government's role must be one of encouraging or facilitating the work of those non-Federal groups that have taken primary responsiblity, up to now, for establishing a graduate medical education system that, if it needs certain improvements, is recognized throughout the world for its overall excellence in training competent physicians.

The second assumption is that any steps taken to modify present methods of funding graduate medical education will be taken with full attention to the implications of those changes for the quality and stability of training programs for health professionals -- physicians as well as others. Provision of adequate health services for the Nation depends on the availability of a range of types of health professionals: physicians, nurses, many kinds of allied health personnel. To the extent

that programs such as Medicare have helped finance both graduate medical education and the clinical training of other types of personnel, any changes in these programs as they relate to the training of physicians must take account of other educational programs.

FY 1986 Budget

As you know, the President's 1986 budget requests no funds for health professions education support. In view of a steadily increasing supply of physicians and nurses, projected National surpluses in these fields by the end of this decade, improving geographic distribution of health professionals, and the need for budgetary constraints, continued Federal subsidy of health professions education programs is no longer required. All major studies of supply and demand for health professionals conclude that virtually all health professions occupations are in excess supply and that supply growth will continue to outstrip demand increases for the remainder of the decade.

Although no budget authority is requested for health professions assistance in 1986, approximately $67 million will continue to be available for student loans from the revolving funds at approximately 1,400 health professions and nursing schools. These repaid loan monies will enable schools to continue providing assistance to economically disadvantaged students. Significantly improved debt collection methods should help ensure an adequate funding source.

In addition, the Health Education Assistance Loan program (HEAL) will provide $100 million of new guarantees for private loans to graduate students in health professions schools.

Current HRSA Programs

Mr. Chairman, current HRSA programs (authorized under Title VII of the PHS Act) relating most directly to graduate medical education are several support programs that partially subsidize the training of primary care physicians. Thus, the Bureau of Health Professions has provided aid to medical and osteopathic schools and other entities as appropriate for family medicine training (residents, faculty, and undergraduate), training in general internal medicine and general pediatrics (residents, faculty), and the establishment of departments of family medicine. In the fiscal year 1985, this aid will total about $60 million. Grants have been awarded under a competitive peer review process to those applicants making the strongest case for receiving assistance. This is so-called "last dollar" aid, which means that the Federal share of costs is limited to that which cannot be raised from other funding sources.

There are strong indications that these primary care training grant programs have been successful in enhancing primary health care delivery over the last decade. My office recently reported a 16 percent decrease in the number of primary care health manpower shortage areas between December 31, 1983, and September 30, 1984, along with a 24 percent decrease in the number of primary care physicians needed in these areas. Between 1973 and 1984 (according to AMA residency directories), the number of family practice programs and filled residency positions grew from 206 to 386 and from 1765 to 7408, respectively. In the field of general pediatrics, Federal aid has enabled programs to increase the time of residents in training in an ambulatory setting; also, a substantial portion of graduates of the programs are located in small cities and

towns in rural areas and in socioeconomically deprived sections of inner cities.

Another of the Bureau of Health Professions' programs that has made a major contribution to the training of primary care physicians is the area health education center, or AHEC, program. This program, also established during the 1970's, was designed to increase the supply of health professionals in areas remote from existing training institutions by developing training programs in these areas. Emphasizing a regional approach to meeting health personnel needs in shortage areas, it has provided funds to medical and osteopathic schools for the purpose of decentralizing education by having portions of training provided in primary medical care shortage areas. Among the training programs supported have been those for primary care residency training. Many AHECs hve continued to operate successfully after the start-up period of Federal support ends.

In addition to providing support for primary care physician training, the Bureau of Health Professions has pursued efforts to improve the availability and quality of information on the status of health professions personnel, including data on physician supply and distribution. Working in cooperation with other Federal agencies, States, local communities, professional organizations, and other groups, we have assembled and analyzed data on current supply of practitioners and students and estimated future requirements for personnel. The Bureau also designates health manpower shortage areas, among them primary care physician shortage areas.

Based on the analysis of data, our most recent report to the Congress on the status of health personnel (May 1984) describes the growth of

physician training programs over the past 20 years, notes the increase in the supply of practitioners, and documents progress in the development of residency training programs in the primary care specialties of internal medicine, family practice, pediatrics, and obstetrics and gynecology. The report also summarizes available data on the extent to which, in part as a consequence of the increasing supply of physicians, more practicing physicians are locating in counties that have lower physician-to-population ratios.

Relation to GMENAC Recommendations: Increasing Physician Surpluses

Mr. Chairman, in 1980 the Graduate Medical Education National Advisory Committee, an advisory body created by the Secretary to coordinate public and private efforts in the quest for an equitable distribution of physician services, produced a series of projections for physician specialty distribution using an "adjusted needs-based" approach. Under this approach, the Committee generated physician service requirements as a function of expected national morbidity, modified by expert opinion on the fraction of ths morbidity requiring medical intervention, within limits on what was achievable by 1990 under expected constraints of the health care system.

Some major findings of GMENAC were: There would be 70,000 more physicians than required in 1990. There would be a surplus in virtually all specialties. The primary care specialties of osteopathic general practice, family practice, general internal medicine, and general pediatrics would be in approximate balance. Shortages would be experienced only in psychiatry and emergency medicine. Based on their findings, GMENAC made a total of forty recommendations, as well as many "supportive recommendations," for action by the Federal and non-Federal sectors.

Key among the GMENAC recommendations for Federal action relating to physician specialty training were that capitation payments to medical schools for the purpose of increasing class size or "influencing specialty choice should be discontinued; that special purpose grants to medical schools should be continued; and that public and private reimbursement policies should be adjusted to emphasize ambulatory care services and training (among other purposes). The Committee called for further study of needs for certain specialties studied by GMENAC only on a tentative basis.

Consistent with the GMENAC recommendations, the Administration successfully sought termination of the authority for capitation grants to medical schools, effective in FY 1982. Overall, programs designed to increase the aggregate supply of physicians have been phased out, or are proposed for termination in FY 1986. Financial support for primary care physician training has been continued through 1985. Requirements for six additional specialties and subspecialties were studied in depth using GMENAC's adjusted needs-based methodology, resulting in a slight decrease from 70,000 to 63,000 in the Committee's projected aggregate physician surplus in 1990.

Since the GMENAC report was published, the Bureau of Health Professions has continued to provide alternative estimates of requirements for physicians based on projected demand for medical services, using a model employing an "adjusted utilization" approach. All of the alternative estimates support projections of large surpluses of health professionals. The "adjusted utilization" approach assumes that recent patterns of medical services utilization and productivity will continue, with adjustments to reflect projected changes in the population

and per capita utilization, among other factors. Using this approach, we estimate surpluses in overall physician supply of about 35,000 in 1990 and rising to about 51,800 in the year 2000.

Recent Bureau estimates of future physician supply provide additional information on the probable specialty distribution of physicians. For example, the number of allopathic and osteopathic physicians in the primary care specialties of internal medicine, general/family practice, and pediatrics is projected to increase by approximately 117,900 between 1981 and 2000. The ratio of primary care physicians to the population is projected to increase from 84 per 100,000 population in 1981 to 115 per 100,000 population in 2000.

Proposed Reform of Graduate Medical Education Funding

Mr. Chairman, we in HRSA have studied with great interest your proposal for reform of the system of Federal funding for graduate medical education. Many of the objectives of the proposal are ones in which we know the Administration concurs: making the education system more responsive to the Nation's health needs, placing restraints on open-ended payments out of the Medicare Hospital Insurance Trust Fund for clinical education costs, and assuring opportunities for residency training to graduates of approved U.S. medical schools, among others. Speaking now strictly from my perspective as HRSA Administrator, and not attempting at this early stage to represent the Administration's thoughts on your proposal, I do have a few comments about particular aspects of the plan.

First, the proposal would require that, in order for a hospital to be reimbursed for direct costs of physician residency training programs, a majority (70 percent is suggested) of all GME positions offered by the hospital or a group of hospitals sharing an affiliation agreement with a

U.S. medical school must be in the primary care specialties. To judge the impact of this requirement, we would need to know how a primary care position would be defined. For example, would fellowship positions in internal medicine residencies beyond the three years required for primary care specialization be included? Would first-year internal medicine residents who are simply meeting basic requirements for another specialty be counted?

We are also concerned about the speed with which the existing primary care training system could be expanded. New and expanded programs of good quality take time to develop. Further, some primary care training is provided by faculty of other specialties; e.g., a family medicine resident's surgical training may be provided by faculty of a co-existing surgical residency program. Would it not be possible that any sharp change in funding for programs in non-primary care specialties would have some negative impact on the development and maintenance of primary care training programs ?

Second, the proposal would supplement the existing residency training quality assurance process (approval by the Accreditation Council for Graduate Medical Education) by requiring all funded programs to be affiliated with medical schools. At present, the Accreditation Council, which is sponsored by the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the American Board of Medical Specialists, and the Council of Medical Specialty Societies (with a representative from the Health Resources and Services Administration to provide ex officio Federal representation), conducts the nationwide accreditation process using 24 specialty-specific

residency review committees in establishing educational and quality standards.

While most persons regard a voluntary medical school affiliation as an educational asset, would it be desirable to require such affiliation? The medical schools would be placed in a position of potentially imposing their own standards of quality, overriding the existing multi-perspective (ACGME) process. Hospitals would be at a considerable disadvantage in negotiating for reasonable financial terms, provision of faculty, and other aspects of their agreements with medical schools.

There would also be the problem of defining what is meant by "affiliation." At present, affiliations take a variety of different forms. Detailed data on the numbers and kinds of affiliations between medical or osteopathic schools and residency programs are not now available to us, although by the end of 1985 we hope to have operable a data base which could provide some of the information needed to help assess the probable impact of a requirement that Federal funding be provided only to affiliated residency programs.

Third, the proposal would provide for payment of educational costs only when at least 75 percent of trainees in a graduate medical education program are graduates of LCME-approved U.S. medical schools. Since 1981, the number of U.S. residents who are foreign medical graduates has leveled off at about 13,000, representing a slightly declining percentage of all residents -- about 18 percent. A reduction in the number of alien FMGs has been offset by an increase in the number of U.S. citizen FMGs. Although the proposed 75 percent requirement does not appear to be unreasonable, is there a possibility a fixed statutory restriction would have the effect of unduly limiting opportunities for genuine exchange visitors from other countries, i.e., physicians who need specialty training in the U.S. in order to help meet health care requirements in their home countries?

Mr. Chairman, this concludes my prepared statement. Dr. Jacoby and I would be happy to answer any questions you may have.

from Senator Kennedy

QUESTIONS FOR DR. ROBERT GRAHAM

Question: Based on Bureau estimates, is it your belief that all medical specialties will be adequately supplied within the next decade?

Answer: As with other health professions, we believe there is an adequate capacity within the United States to produce in the aggregate sufficient numbers of specialty physicians. Determination of whether all medical specialties will "be adequately supplied," however, is essentially a matter of definition. Medical school graduates select the specialties that are attractive to them or that have market value in their eyes, taking into account such factors as anticipated income and reimbursement levels. The adequacy of supply in a specialty thus may be related more to demand than to need which is based on many different factors.

Questions related to adequacy levels are partly answered by estimating future supply in the medical specialties. This was done recently by the Bureau of Health Professions and reported in Projections of Physician Supply in the U.S. (Bureau of Health Professions, Office of Data Analysis and Management, ODAM Report No. 3-85). Those projections showed that of the 35 specialties covered, only three--pediatric allergy, occupational medicine and public health--will not show increases in their absolute numbers between 1981 and 1990. Almost all of the remainder will show significant growth, well above the growth in population.

In terms of broad specialty groups, the largest increases are projected to occur in the medical specialties other than those in the primary care category. Increases in the number of primary care specialists are projected to increase 29 percent between 1981 and 1990. The "other medical specialties" are projected to increase 40 percent during this period. The surgical specialties are projected to grow the least, with a projected average increase of 20 percent. Population growth, by comparison, is projected to amount to only about 9 percent during this period.

QUESTION:

What is the breadth and magnitude of support by the Bureau of Health Professions to primary care training? What impact do you anticipate on primary care programs if the support is discontinued?

ANSWER:

In FY 1985, $60,000,000 is specifically available for primary care physician training programs. These include programs for undergraduate, graduate, and faculty development training in family medicine, graduate and faculty development training in general internal medicine and general pediatrics, and establishment of family medicine departments. Emphasis is placed on continuity of care, preventive health, and cost-effective health care, among other factors. The specific amounts for each program by budgetary line follow:

Family Medicine Departments	$7,500,000
Other Family Medicine Training	$34,000,000
General Internal Medicine and General Pediatrics	$18,500,000
	$60,000,000

The precise impact of discontinuing this support is not known. However, some hospitals and schools probably would be forced to consider retrenchment in their training programs.

Over the years the Bureau has advised schools and hospitals to assume an increased share of the total costs of their training programs. As part of the objective review process an assessment is made of the degree to which a project will become self-sufficient after Federal support. This assessment is continued after a project is funded.

Senator QUAYLE. Our final panel today is Dr. David Thompson, Dr. J. Robert Buchanan, and Dr. Robert S. Stone.

The first witness, on behalf of the American Hospital Association, is Dr. David Thompson, director of the Society of the New York Hospital in New York.

Dr. Thompson?

STATEMENT OF DR. DAVID D. THOMPSON, DIRECTOR, THE SOCIETY OF THE NEW YORK HOSPITAL, NEW YORK, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; DR. J. ROBERT BUCHANAN, DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MA, ON BEHALF OF AMERICAN MEDICAL COLLEGES, AND DR. ROBERT S. STONE, DEAN, COLLEGE OF MEDICINE, TEXAS A&M UNIVERSITY, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DIVISION OF FEDERAL LEGISLATION, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL, AND DR. ROY SCHWARZ, VICE PRESIDENT FOR MEDICAL EDUCATION AND SCIENTIFIC POLICY, AMERICAN MEDICAL ASSOCIATION

Dr. THOMPSON. Good morning, Mr. Chairman and Senator Simon.

I would like to make just a few comments which really highlight the written testimony from the American Hospital Association, which has been submitted and you have seen, and then just make a couple of comments which are really more my own experiences with this most difficult problem.

As you mentioned, I serve as the director of the Society of the New York Hospital, which is a 1,418-bed teaching hospital in New York City, affiliated with Cornell University Medical College.

I welcome the opportunity to appear before you today to present the views of the American Hospital Association on the issue of financing graduate medical education and to offer some of my own experience and opinions to assist you in developing your proposal.

Let me preface my remarks by stating that the American Hospital Association recognizes the importance of the issue of financing graduate medical education. Its recently formed Study Group on Financing Graduate Medical Education will hold its second meet-

ing later this week, and it is charged with examining both the current system and proposals for change.

The American Hospital Association will be pleased to share the results of this group's deliberations with the subcommittee.

The adoption of prospective pricing for Medicare reimbursement represents a radical change in hospital payment. And, while the long-term effects of this change are not clear, it is apparent that hospitals have been responding positively, despite the uncertainty of the new environment.

As we move toward national rates, current inequities in the system, such as the inability of the DRG system to adequately account for the severity of illness of patients treated in teaching hospitals, will become magnified. Therefore, it is essential that we move cautiously before adopting any dramatic change in the way Medicare and other payers help pay for graduate medical education in these institutions.

I am pleased to note that in your proposal, you acknowledge the interdependence of education and patient care in graduate medical education programs. It is also important to recognize the added benefits of this interdependence, the positive effect on quality of care through encouragement of peer review, provision of educational opportunities for attending staff, and the attraction of highly qualified physicians to the hospital's medical staff. These benefits accrue to the teaching hospital, the physicians it trains, and the community it serves.

Your proposal, Mr. Chairman, would result in substantial changes in the current system of funding graduate medical education through a focus on physician manpower issues. Points that should be carefully evaluated before instituting such a shift in policy include: One, the fact that training programs allow teaching hospitals to provide many complex and costly services in a less costly manner, and two, the fact that medical schools currently exert less control over teaching hospitals than your proposal assumes.

In conclusion, it is unclear what impact these changes would have on the training of physicians and on the provision of patient care. Perhaps it would be best to move very cautiously until some of the questions are answered.

If I might just take 1 minute for a personal observation and experience in this field, you said at the outset, Senator Quayle, that this discussion over medical manpower has been going on for a good many years, and lots of data have been accumulated on the subject, yet it remains a very dififcult one to come to grips with. I was involved in one of the early seventies' studies of medical manpower, and the questions of specialty distribution and geographical distribution were very urgent ones then, as they are now. The difficulty in coming up with a plan to deal with it, I think, is still very evident. Some of the reasons then, I think, are equally pertinent now.

One is, you have difficulty in measuring what physicians actually do. This became obvious to us when we were looking at the problem. One study, which was done with cardiologists at the time, indicated that they varied greatly in what they actually did. Some of them spent the great bulk of their time doing cardiology, but there

were many others who spent the bulk of their time doing primary care. So the measure of just what physicians do once they get out and practice remains a very difficult thing to measure.

Second, I think the problem that was mentioned about geographic distribution often gets tied into this, as you would imagine. I think the changes that occur in medical practice influence this in many ways. And, as has been mentioned earlier, perhaps it is not really pertinent any longer, or the best way to go, to suggest that physicians occupy all of the underserved areas. Perhaps nurse practitioners or physicians' assistants, tied in with medical supervision, make more sense in rural areas and perhaps even in inner city areas.

So that, when one looks at numbers and attempts to relate them to practice, you are really relating them to a shifting scene.

Another point which was made which I think powerfully influences what physicians will be doing is prepaid medical practice. Here, clearly, where the emphasis is on primary care and on prevention, the attraction of young physicians will increase. The marketplace will attract them to a primary care specialty.

I think what is going on out there, and changing rapidly, in fact, is moving more graduates toward primary care for some of these reasons. As was also pointed out, we do not want to lose the quality of our specialty care. I think none of us would like the idea of being operated on by a surgeon who did not have good training, and it takes a long time to train surgeons well.

I do not think there is a prescribed period of time for each specialty. The fact that they range from 3 to 7 years is no accident. I think that what it tell us is, and that experience has shown, it takes longer to be well-qualified for one specialty than another.

In all of this discussion, we are not arguing about the importance of primary care—I would hate to see us diminish the importance of the other specialties.

Thank you.

Senator QUAYLE. Thank you very much, Dr. Thompson.

[The prepared statement of Dr. Thompson and responses to questions submitted by Senator Kennedy follow:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
OF THE SENATE LABOR & HUMAN RESOURCES COMMITTEE
ON FINANCING GRADUATE MEDICAL EDUCATION
March 25, 1985

SUMMARY

The hospital industry is in a state of ferment. Recent changes in Medicare policies such as the adoption of a prospective pricing system (PPS) and the piecemeal implementation of the Peer Review Organization program, while creating many positive incentives, have also made uncertainty the central characteristic of the hospital environment. Early data suggest that hospitals are responding positively to the implementation of the PPS system. However, as the movement toward national rates continues, many hospitals may experience significant financial losses. In some hospitals, these losses will reflect the inability of the diagnosis-related group (DRG) system to adequately account for the severity of illness of patients treated in teaching and referral centers. Since many of these hospitals are involved in medical education, changes in Medicare's medical education payment policies should be postponed until the impact of PPS on referral hospitals is better understood.

Medical education is not something separate and distinct from patient care. Interns and residents receive an education as well as provide patient care during their residencies. The involvement of an institution in medical education also can have a positive effect on quality of care by encouraging peer review, providing educational opportunities for attending staff, and attracting highly qualified physicians to the hospital's medical staff. Similarly, the types of patient care provided by a hospital have an impact on the quality of the educational experience available to interns and residents. Consequently, changes in the method of payment for medical education will lead to changes in patient care, and changes in payment for patient care may alter the ability of hospitals to provide an adequate educational experience. However, the complex relationship between patient services and medical education is not easily defined, reflecting the fact that medical education is both a product and a resource. Current Medicare accounting methods do not permit a precise allocation of education costs between education, per se, and patient care. Until the role of medical education in patient care is more precisely identified, changes in payment methods should only be studied, not adopted.

INTRODUCTION

Mr. Chairman, I am Dr. David D. Thompson, director of the Society of the New York Hospital, a 1,418-bed teaching hospital in New York City that is affiliated with Cornell University Medical College. I am pleased to be here on behalf of the American Hospital Association to present its views on the general issue of financing graduate medical education and, more specifically, on your proposal as outlined in the Congressional Record of January 31, 1985.

At the outset, I would like to point out to the Subcommittee that the AHA is currently working to develop its formal position on these very important issues. A Study Group on Financing Graduate Medical Education has been formed and has held its first meeting; a second meeting is scheduled for later this week. This group will examine the current system of payment for graduate medical education and a variety of proposals for modification and change. The AHA will be pleased to share with the Subcommittee the results of this study groups's deliberations, but today I would like to share some preliminary comments and concerns on the issue of graduate medical education.

Last fall, Senator Durenberger held hearings on a proposal to create within Medicare a block grant program, operating through the states, to pay for Medicare's share of direct graduate medical education costs. The AHA opposed that proposal, both because it would involve state government inappropriately in the administration of PPS, and because it does not recognize the complex relationship between medical education and patient services.

AHA continues to oppose changes in Medicare's method of payment for medical education until the implications of current payment policies for teaching and referral hospitals are better understood. Immediate change is not necessary. While the long-term outlook of the Medicare program continues to be troublesome, an immediate crisis has been averted, largely because of the strong, positive response by hospitals to the incentives of the PPS and the continuing strong performance of the economy. The 1985 report of the trustees of the Medicare Trust Fund has not yet been released, but the industry's performance during 1984 was substantially better than the trustees assumed it would be in their report of the previous year.

-- The trustees assumed "input prices" would rise by 5.9 percent during calendar year 1984; the actual increase was 5.7 percent.

-- The trustees assumed admissions would increase by 2.0 percent during calendar year 1984; admissions actually declined by 2.9 percent during the year.

-- The trustees assumed hospital employment would continue to increase more rapidly than employment in other sectors of the economy; hospital employment actually declined during 1984.

Statistics clearly indicate that hospitals have responded rapidly and positively to the new environment, despite considerable uncertainty. Most important, the response has not been limited to Medicare. Total hospital expenses for the past year have increased by only 4.5 percent, while inpatient

expenses increased by only 3.2 percent. Given this strong performance, there is time to assess carefully the options for further reform. Such assessment is critical because the longer-term effects of implementing PPS are still unknown. If the movement toward national rates is based on a mistaken assumption that DRGs accurately describe the types of patients admitted to hospitals, the transition to national rates could have a detrimental effect on hospitals providing advanced, tertiary services, and many of these hospitals are the ones involved in medical education. It is, therefore, essential to explore modifications to the current payment system, such as DRG-specific price blending, that will reduce the potential for these undesirable effects.

TEACHING HOSPITALS AND THE PAYMENT SYSTEM

The prospective pricing policy enacted by Congress is intended to reduce differences in the amount paid for similar services provided in different hospitals. PPS represents a major change in hospital payment, and the long-term effects of this change are as yet unknown. The Congressional Budget Office's preliminary analysis of the impact of prospective pricing suggests that teaching hospitals, particularly those without exceptionally large teaching programs, are especially vulnerable to revenue losses as the system moves toward national rates. The system of DRGs is still largely untested, and evidence is accumulating that differences in case mix beyond those picked up by DRGs have a legitimate effect on hospital costs. The development of an appropriate policy is further complicated by the absence of data on both the costs of medical education and the contribution of medical education to patient care.

To partially compensate for the limitations of DRGs in this area, Congress included a special "indirect" medical education factor. We believe this factor is misnamed, because it confuses the effect of education on costs with the effects of treating a more complex and costly case mix. Medicare cost finding techniques, as well as the statistical techniques used by the Health Care Financing Administration (HCFA), cannot clearly identify the cost of education. In fact, it probably us impossible to separate the costs of education from the costs of patient care because the two activities are interdependent. Education programs increase the ability of hospitals to offer certain specialized services by attracting qualified physicians and by ensuring physician coverage for patients with severe or complex illnesses. Similarly, it is the tertiary services that make teaching hospitals suitable sites for medical education. Reducing support for medical education will inevitably have an impact on the ability of hospitals to continue their medical education programs, but also on the ability of teaching hospitals to continue providing tertiary services.

Recent proposals to cut the indirect medical education factor by 50 percent increase the vulnerability of teaching hospitals. Such an action, while being proposed as part of a budget "freeze" actually would reduce the revenues of all teaching hospitals, causing severe financial hardship for many referral centers. It is important to recognize that, under the Medicare PPS, the total revenue available to the hospital to support its operations is constrained, even though a distinction is made between operating costs -- which are to be covered by the DRG-based price -- and the "non"-operating costs, such as medical education and capital. If a DRG price, including the allowance for

the so-called indirect costs of medical education, does not cover the hospital's operating costs, the hospital will have to eliminate some of the resources it currently employs. As these cutbacks occur, the ability of the hospital to continue its commitment to medical education may be seriously eroded. Similarly, reductions in funding for medical education will necessitate cutbacks in education programs. As education programs are cut back, it may be increasingly difficult to continue providing the range or level of tertiary services offered by the hospital, particularly in those areas where house staff are an integral part of patient care.

Teaching hospitals occupy a critical position in the nation's hospital system. While HCFA has not released specific data, it is believed that teaching hospitals provide a disproportionate amount of care for "outlier" patients--patients whose lengths of stay exceed the average for their DRGs--suggesting that the patients seen in teaching hospitals are, on average, more severely ill than the patients seen in non-teaching hospitals. While the Medicare payment system does provide additional payments for outlier patients, these additional payments cover only the portion of the patient's stay designated as the outlier days or costs. It does not recognize the higher average costs that will be experienced by a hospital treating a disproportionate number of outlier cases.

A simple, hypothetical example illustrates the problem. Hospitals A and B are located in the same community and are paid the same "standardized" price of $3,000 per case. Hospital A admits no outlier patients, and incurs costs of $3,000 per case. In contrast, 10 percent of Hospital B's patients are

outliers. The average cost-per-case of the non-outlier patients admitted to hospital B is also $3,000, but the average cost of outlier patients is $14,000. The additional payment for outlier patients is limited to 60 percent of the amount in excess of $13,000, or $600. Hospital B is, consequently, paid $3,060 per case, despite the fact that its costs are $4,100 per case, resulting in a loss of $1,040 per case even though it is as efficient as hospital A in providing care for non-outlier patients. It should be recognized that hospital B will incur a loss, no matter how "efficient" it becomes, as long as it continues to treat "outlier" patients.

Teaching hospitals also provide much of the referral or tertiary care needed by the Medicare population. The role of teaching hospitals as referral centers is not restricted to those hospitals directly associated with medical schools. Smaller teaching hospitals, and teaching hospitals involved primarily in graduate medical education, also are important sources of tertiary services in their communities. Efforts to reform payment for medical education costs must recognize that the current "indirect" payment has been characterized as a proxy for a severity index, and that treatment of the more severely ill patients means provision of referral services. Therefore, involvement in medical education, and not simply medical school affiliation, is the appropriate indicator of referral status.

Changes in the method of payment for medical education are likely to disrupt, rather than rationalize, the delivery system. Hospitals are still uncertain about their future financial viability under PPS, particularly as Congress continues to tinker with the pricing formula in an effort to produce

short-term budget savings. Changes in the pricing system should be considered, but only when they are needed to correct fundamental flaws in the design of PPS or in the data upon which that system was based. DRG-specific price blending is such a proposal, as is the institution of adjustments for the higher costs experienced by hospitals treating a disproportionate number of low-income patients, or efforts to correct the inaccuracies of the Bureau of Labor Statistics data on which the area wage index is based, or efforts to develop more realistic definitions of hospital labor markets. All of these problems can create significant inequities. Before the expansion of PPS is considered, and before a new method of handling the cost of medical education is adopted, the effects of the changes that already have been made must be determined. It is more important for the immediate future to deal with the issues created by the adoption of PPS , and the inequities that have resulted, than to move on to new areas. Only after these issues are resolved, should Congress address issues such as the reform of medical education.

THE QUAYLE PROPOSAL

The proposal recently outlined by Senator Quayle clearly recognizes that efforts to reform Medicare's payment policies for medical education cannot be based simply on the desire to save money. Changes in Medicare's payment policies will have serious consequences for national manpower policy and the content of graduate medical education, as well as patient care. The movement toward competitively oriented payment systems in both the public and private sectors is demonstrating the superiority of market forces as a means of containing the costs of medical care. However, competitive payment mechanisms

are creating--or at least highlighting--several of the more difficult health policy issues, including the problems of financing medical care for the medically indigent and financing medical education. Fundamental reforms probably will be required to address these issues. Such reforms will take time to develop, particularly as the environment in which they will operate is still rapidly evolving. The type of financing mechanism for medical education that will be appropriate in the new environment cannot be determined until the pace of change slows.

The Quayle proposals begin to grapple with the many difficult issues that must be addressed before a rational policy for financing medical education can be developed. However, the proposals appear to rely on the Medicare program to set the broad direction for education policy. While Medicare, along with other third-party payers, will have a significant role in implementing manpower policy, the formulation of that policy should be located outside the program. Medicare, like other payers, has an incentive to minimize payment--if not eliminate payment outright--for medical education. Responsibility for establishing education policy should involve groups other than third-party payers, including representatives of accrediting bodies, hospitals providing medical education, medical schools, and the public. In determining the appropriate number and specialty mix of physicians to be trained, market factors and community needs should be among the foremost considerations.

Several of the assumptions underlying the Quayle proposal deserve comment. First, the proposal refers to, but does not adequately recognize, the fact

that graduate medical education programs allow hospitals to provide services that would, in the absence of a training program, be more costly to produce. Because graduate medical education is both a "product" and a "resource" the services received by patients from interns and residents in teaching hospitals may be provided at lower cost than would be the case if they were provided by physicians in private practice. Similarly, the proposal does not recognize that reducing the number of training slots in a hospital may reduce the capacity of various specialized services.

Second, the proposal appears to reflect a belief that the current accrediting program operated by the Accreditation Council for Graduate Medical Education (ACGME) is not exercising sufficient control over the quality of GME programs. AHA believes that ACGME, which sets minimum requirements for the quality of GME programs, is working well, and that the responsibility for evaluating the quality of such programs should remain within the private sector. Although the ACGME does not require affiliation, 98% of all teaching hospitals, in fact, have some sort of affiliation agreement with a medical school. However, it is important to keep in mind that many of the nation's leading teaching hospitals are not the primary affiliates of medical schools.

Third, the proposal does not clearly describe how the allocation of training positions between primary care and non-primary care specialties would be accomplished. It does recognize that the specialty mix of a single hospital's GME program will reflect the type of specialty and referral services it provides, but does not clearly define how the specialty mix of a "group" of affiliated hospitals would be evaluated. The proposal vests the decision

about specialty mix with medical schools, but does not identify any limits on the authority of the medical school to dictate the specialty mix of affiliated hospitals. Nor does it identify how the medical schools' decisions about specialty mix would be evaluated and compliance with federal guidelines enforced. An appropriate policy must recognize that the specialty mix of the GME program operated by a hospital both determines and is determined by the case mix of the hospital, and that referral hospitals are not necessarily the most appropriate locations for training primary care specialists, the majority of whose training often involves outpatient rather than inpatient experience.

Fourth, the Quayle proposal appears to contemplate a more intensive involvement of the federal government, including decisions about the level of intern and resident stipends. The number of training slots offered by a hospital, as well as the level of stipends, depends on a wide number of factors, such as the availability of faculty and the case mix of the hospital, and is best determined by the hospital, working with accrediting bodies, other hospitals involved in an education program, and any medical schools with which the hospital may be affiliated. The suggested approach appears to rely on Medicare to enforce federal guidelines on training programs and may lead to a formulistic approach that is not responsive to local needs and capabilities.

CONCLUSION

The issue of medical education is enormously complex, involving decisions affecting every aspect of the health care system. The future of medical education is affected by both the policies overtly addressing education and

the policies affecting patient care. At the same time, policies affecting medical education have implications for patient care. An appropriate policy can emerge only from a full and intensive debate of these important issues, combined with a more complete understanding of cost and process of medical education, the relationship between education and patient care, and the implications of the financing environment for hospitals involved in medical education. The enormous changes that have occurred in the past several years have created a great uncertainty about the ability of teaching hospitals to continue providing the types of services they have. Until this uncertainty is reduced, we should proceed cautiously.

From Senator Kennedy

QUESTION FOR DAVID THOMPSON, M.D.
AMERICAN HOSPITAL ASSOCIATION

1) DO YOU BELIEVE THE CURRENT MIX OF RESIDENCY TRAINING POSITIONS ACCURATELY REFLECT NATIONAL NEEDS?

IF NOT, HOW DO YOU BELIEVE IT SHOULD BE ALTERED?

Despite years of research and argument, there are no definitive ways of measuring or identifying a shortage or surplus of physicians, particularly by specialty. At any point in time, the distribution of specialties will reflect the demand and need for physicians in each specialty. As the methods of organizing and delivering services change, the need for various specialty physicians will change, and the most efficient means of insuring an adequate supply is through the operation of a market-like mechanism. Recent changes in such organization and delivery appear to be having an effect on demand and should result in appropriate modifications in the specialty mix of both graduating and practicing physicians. Any attempt by the federal government to intervene could produce more problems than it solves, espeically if it results--either directly or indirectly--in the training of more physicians in a particular specialty than would be needed or demanded by the population at that time.

Senator QUAYLE. Dr. J. Robert Buchanan, on behalf of the Association of American Medical Colleges, is director of Massachusetts General Hospital in Boston.

Dr. Buchanan.

Dr. BUCHANAN. Thank you, Mr. Chairman.

I am pleased to have an opportunity to speak on this important subject this morning. I am the chairman of the AAMC's Committee on Financing Graduate Medical Education. I believe you have received a copy of our "Statement of Issues," as well as a copy of the written testimony.

Just for a second I would like to put on yet another hat, which is that of chairman of the Liaison Committee on Medical Education (LCME) and former dean of Cornell University Medical College. I want to remind everybody that what occurs during the graduate medical education process is necessarily conditioned by what comes out of the undergraduate medical education system; these two components of medical education are not the same. There is a dysfunction between the control of the undergraduate medical education process in this country and that of graduate medical education. In many, many instances, medical schools do not control the residency programs—certainly, not in a direct fashion. Very frequently, we are dealing with two corporate entities, both of which see themselves as sovereign.

We also have to be concerned about the students who come out of the medical education process. We have to look at the numbers; we have to look at their interests, their competencies, and their desire to live in certain parts of the country and to do certain kinds of things. We may be able to narrow those choices, but I suspect in our society, it would be very difficult to engineer those choices with any high degree of precision. And I suspect most of us would not think such engineering would be a wise thing to do.

When contemplating changes in the current system, we need to recognize that about 50 percent of graduate medical education takes place in about 125 major teaching hospitals in this country. The other 50 percent takes place in 1,100 hospitals spread across the country. So we are at the one time talking about a highly dispersed process and a highly concentrated process. The output of these programs is a dynamic pool of trained physicians who find their way into a variety of positions jobs, and solo practices, depending upon a whole variety of factors we have heard enumerated this morning.

I think, however, in view of this dispersion and concentration going on concurrently, it would be very difficult indeed to engineer the placement of physicians on a State-by-State basis—extremely difficult. I think that it would be very difficult for officials within New York State to make determinations about the numbers and types of physicians that should be trained within the State when you consider that New York is a major exporter of trained physicians, It trains physicians for the benefit of our society-at-large, not just to fulfill the needs of its own State population.

Fifty-five percent of graduate medical education in this country is in eight States, which have 47 percent of the population. So you can see it is a skewed distribution.

As Dr. Thompson has already said, because of the other things that are going on in the lives of the teaching hospitals, it is especially important that we attempt to provide a stable environment for graduate medical education. Without that, the decades of investment and the creation of the best programs of their sort anywhere in the world will be endangered.

There are problems, but I am not even sure we could all agree that there will be, in fact, will be an oversupply, since we have not had an experience with a number of new developments. The first is our population is graying, getting much older and not younger. We do not know precisely what the effect will be on utilization of services and the number of health professional needed.

Growth of prepaid care is another relatively unknown factor, as is the changing workweek and expectations of professionls. A very important change in recent years is the fact that now 30 percent of the medical students are women. The impact of this on the delivery system is still unknown.

Applications to medical school, at the same time, are sliding down. For the first time in many years, there are fewer than two applications for each place in American medical schools. The field is beginning, apparently, to look less attractive to young people, and we need to be concerned about what that is going to mean to the physician supply as well.

In other words, there are forces here that may greatly influence these projections of a physician surplus.

Finally, most importantly, we need the consider whether the teaching hospitals in this new price-sensitive environment will be able to continue to sponsor graduate medical education while remaining economically viable entities. They may find it necessary to reduce the number of positions they offer in graduate medical education to compete successfully in the prepaid and price-competitive markets. We know nothing, or very little, at least, about the teaching hospitals' responses to the new environment.

The Committee I chair for the AAMC is in accord that it would be desirable to shift toward more primary or general care. We are not clear as to what percentage of residency positions ought to be devoted to primary care. We think at the moment that 70 percent sounds fairly high, and that it would cause a fairly severe realignment of the primary care specialty opportunities at the entry level in this country. It would probably cause a need for the creation of several thousand new positions in the primary care specialties. Are the hospitals going to be ready, willing, and able to create those spots in the new economic environment that we face?

We have looked at two options on how best to create a shift toward primary care. The first is to limit the number of years supported and to decrease by that the ease of financing specialty care training. It makes it more difficult for an individual to go through 7 years of surgical training if the hospital where he is working is only reimbursed for the first 3 or 4 years of that. Other means of support will need to be found for those additional years, and it probably means that the number of such positions to be offered will be reduced.

The other alternative we have looked at is limiting the number of physicians supported and funding the training for those physi-

cians through initial board certification. In that instance, we agree that limiting the number of positions supported would probably require some kind of a national agency, preferably in the private sector. Acting on projections, such as those done by the Graduate Medical Education National Advisory Committeee [GMENAC], the agency would assign to institutions limited numbers of slots in the various specialties.

I can tell you at the moment, there is no consensus in the AAMC Committee as to which option we should recommend. Over the years, I have served on a good many committees looking at difficult issues, and I have never served on one where we seem to have such disparity of preference. I have likened it to getting one's arms around a column of smoke.

It is very clear in our minds that it would be preferable to limit support to graduates of LCME-approved schools. We are mindful, however, that that would generate some very difficult problems for areas where FMG's have largely populated certain kinds of physician roles. This is another problem that a national agency would have to consider as it assigned specialty training slots across the country. We cannot afford to leave many of those positions vacant.

On the other hand, if in fact we do face a surplus of physicians, it should be possible to support the needs of those institutions with fully educated physicians that trained elsewhere in the system.

I think that concludes my remarks. Thank you very much.

Senator QUAYLE. Thank you, Dr. Buchanan.

[The prepared statement of Dr. Buchanan, responses to questions of Senator Kennedy, and additional material supplied follow:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Financing Graduate Medical Education

Presented to the Subcommittee on Employment and Productivity

U.S. Senate Committee on Labor and Human Resources

by

J. Robert Buchanan, M.D.
General Director, Massachusetts General Hospital
and
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March 25, 1985

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges welcomes the opportunity to testify at this hearing on Federal funding of graduate medical education. The AAMC, which represents all of the nation's medical schools, 73 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in all aspects of medical education in the United States. If future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component. Moreover, we must maintain the capabilities and strengths of our system in the face of dramatic changes in the environment faced by teaching hospitals, medical schools and clinical faculty.

Our present system for graduate (GME) medical education and its financing has much to commend it. Nevertheless GME rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation, and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and based on an extensive understanding of both the nature of the teaching hospitals in which GME is carried out and the nature of graduate medical education itself.

Contemporary American teaching hospitals are among our nation's most complex enterprises. In addition to the basic hospital services of primary and secondary inpatient care, teaching hospitals provide the bulk of the nation's tertiary care for the most seriously ill; regionalized special care and stand-by services; clinical training of physicians and other health care personnel; access to medical services for disproportional numbers of the poor and medically indigent; and the development and testing of new diagnostic and treatment

services. Significantly, these multiple products are not independently provided in separate corporate divisions. Rather, the teaching hospital's added responsibilities are generally fulfilled in a single organization with multiple, interrelated objectives. While this hearing considers only one of the special responsibilities of teaching hospitals--graduate medical education--the AAMC must note that the future of teaching/tertiary care hospitals rests on adequate societal support of all these specialized functions.

Contemporary Graduate Medical Education

Graduate medical education is the phase of formal medical education that begins at graduation from medical school and ends after the educational requirements for one of the medical specialty certifying boards have been completed. The term "residency" is commonly used to describe that period of graduate medical education.

Graduate medical education has become as important as undergraduate medical education in the preparation of physicians. It has evolved from a short period of practical experience in a hospital into a formalized, structured educational program, the completion of which is necessary for physicians to be capable of practicing medicine at a level consistent with current knowledge and technology and anticipated developments. In the 1980s, over 16,000 students will graduate annually from the 127 medical schools accredited by the Liaison Committee on Medical Education. The vast majority will spend three to seven years as residents in graduate medical education.

As reported in the current issue of the Directory of Residency Training Programs, there were 74,495 residents in GME on September 1, 1984. This training was provided in a total of 1,554 institutions, the vast majority of which were hospitals. While simple division would suggest an average of 48 residents per

training institution, this is misleading. The 100 non-Federal AAMC member hospitals with the largest residency programs were providing training for 46% of the total residency complement. Thus, while a large number of hospitals (and some other agencies) are involved in residency training, less than two percent of all hospitals provide training for nearly one-half of all residents.

The Directory of Residency Training Programs presently lists accredited residency programs in 40 specialties. The Directory's tabulation shows, however, that 60% of all residents are training in five fields of specialization: internal medicine (24.4%), general surgery (11.0%), family practice (9.9%), pediatrics (8.1%), and obstetrics/gynecology (6.2%). These are the specialties that most Americans use for primary medical and surgical care.

It should also be noted that 55% of residency training takes place in eight states: New York, California, Pennsylvania, Texas, Illinois, Ohio, Massachusetts, and Michigan. While this may appear at first to be a very high percentage, these states contain 47% of the population according to the 1980 census.

The key conclusion from a review of residency program size, concentration of specialties, and location of training is clear: while the majority of residents are concentrated in a small number of hospitals, specialties, and states, the remaining residents are widely distributed. With this heavy concentration but broad dispersion, public policy makers must carefully consider the impact of proposed policies on both the heavy concentrations as well as the broader distribution.

Under the present system of graduate medical education, residency training is financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984

survey of stipends paid to housestaff, show 81% of the stipends are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes the importance of hospital revenue is characteristic of the total costs as well.

The data presented on residency financing excludes Federal hospitals, both Veterans Administration and military. A significant number of residents train in these hospitals, with the VA alone providing training for approximately 10% of all residents. Funds for these residents are provided to VA and military hospitals as a part of their Federal appropriation.

In addition, a limited amount of Federal support for residency training in general internal medicine and pediatrics and family practice is available from the Public Health Service. In FY 1983, $45 million was appropriated for these grants. For FY 1986, the President's budget proposes to eliminate this support. A number of states also provide special funding for family practice residencies. Thus, Federal and state appropriations provide only a highly limited and potentially diminishing source of funding for GME.

To obtain the necessary revenues, non-Federal teaching hospitals include residency program expenses in setting charges and determining reimbursable costs. The present Medicare program presents an excellent example of how this practice works to support graduate medical, nursing, and allied health education.

Medicare Payments

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly discribed in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the added costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated

(or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes expenses incurred by that cost center and allocated overhead.

"Indirect Medical Education" Adjustment

In the Secretary's report on Hospital Prospective Payment for Medicare, DHHS proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. As Congressional committees considered the proposed Medicare prospective payment system early in 1983, the Congressional Budget Office (CBO) prepared estimates of the impact of the new payment system including the resident-to-bed adjustment on different types of hospitals. Hospitals were compared on the basis of region, urban/rural location, bed size, ownership and teaching status. CBO estimates showed that teaching hospitals would suffer disproportionate revenue losses under the proposal and that the amount of the loss would be relatively greater for hospitals with at least .25 residents per bed than for hospitals with lower resident-to-bed ratios. Because the Department's proposed adjustment did not provide equitable treatment for tertiary care/teaching hospitals, Congressional committees asked CBO staff to estimate prospective payment impacts using a doubling of the Department's proposed adjustment. The resulting estimates showed teaching hospitals would be benefited or penalized under the new sytem in approximately the same proportion as non-teaching hospitals. Thus, a doubling of the proposed resident-to-bed adjustment provided the desired equity between teaching and non-teaching hospitals.

Congress clearly recognized the multiple deficiencies the adjustment would help correct.

> This adjustment is provided in the light of doubts ... About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching insititutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

In the AAMC's judgment, the resident-to-bed ratio serves as a proxy to adjust for inadequacies in prospective payment, including:

- o inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals;
- o no recognition for the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;
- o failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- o decreased productivity which results from including trainees in the hospital programs; and
- o additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is, in fact, a proxy measure to provide

appropriate compensation for the added patient service costs borne by teaching hospitals. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception and commissioned HCFA's former research director, Judith Lave, Ph.D., to prepare an objective review of the historical development of the adjustment and to recommend improvements in the Prospective Payment System. Copies of Dr. Lave's paper are attached.

Vulnerabilities and Benefits

Medicare's participation in the financing of graduate medical education faces several challenges. First, to preserve budget neutrality, any special funding for the multiple missions of teaching hospitals reduces the general patient care payment rate for all hospitals, both non-teaching and teaching. Since most hospitals are non-teaching, some do not support this reduction in the general payment rate. Secondly, teaching hospitals vary in the intensity of their medical education activities. Teaching hospitals with small residency programs have less at stake than teaching hospitals with major programs. Lastly as Congress considers options to reduce the deficit, payments identified with medical education may be more vulnerable than payments for patient care.

Because of these vulnerabilities, two benefits of the present Medicare system should be acknowledged. First, Medicare regulations define residents caring for inpatients as a hospital cost. Therefore, residents are not allowed to bill Medicare on a fee basis for professional services. This is a major savings in Medicare Part B expenditures. For example, in the Tax Equity and Fiscal Responsibility Act of 1982, Congress incorporated in statute the long-standing practice in most teaching hospitals that Medicare patients could

not be charged an assistants-at-surgery fee when a resident is involved in the case unless certain exceptions were met. Similarly, residents performing histories and physicals or administering treatments are not allowed to bill for these services. Thus, while Part A costs are increased to fund residents and their training programs, Part B costs are reduced.

Secondly, while the Medicare program serves primarily today's senior citizens and the disabled, it is financed primarily by taxes paid by the employed. Since Medicare's participation in financing graduate medical education helps to ensure that tomorrow's retiree is served by a fully trained physician, GME dollars spent today serve both today's beneficiary and tomorrow's retirees.

Teaching Hospital Finances

While teaching hospitals have greater expenses per admission than non-teaching hospitals, additional products are produced: medical, nursing, and allied health student are trained; new technologies are introduced; and complex patient services are provided. Historically, these added costs have been financed primarily with increased charges and reimbursement using several types of cost shifting:

- o patient service revenues have supported graduate medical education,
- o routine service revenues have supported tertiary care patients,
- o revenues from high volume ancillary services have supported low volume services, and
- o payments from paying patients have supported charity care patients

This financing pattern has allowed teaching hospitals to meet the needs of their communities and the AAMC has supported it. For example, as recently as 1981, an AAMC Task Force on Graduate Medical Education which comprehensively studied GME recommended that, "graduate medical education should continue to be financed from multiple sources, with the principle source being the general operating revenues of teaching hospitals" (emphasis added).

The current financing system has a number of strengths. To date, patient service revenue has provided a dependable source of funding. This is important for programs with a three to seven year duration. Residents want and deserve a reasonable assurance that the program they enter will still be strong when they are finishing. Secondly, hospitals have been able to develop residency programs that complement and support the hospital's patient care programs. Third, because direct operating costs have been paid on a cost basis, professional judgments on the balance of patient care service and education activities in residency programs have not been influenced by financial incentives. Fourth, because the financial requirements of graduate medical education have been met, a small number of teaching hospitals have trained physicians who go on to serve other communities and hospitals. Finally, the stability of the financing system has enabled accreditation agencies realistically to assume stability of the residency program's quality.

The present financing system, however, does have its weaknesses. First in an increasingly price competitive market for hospital services, hospitals having higher patient charges to support special missions are at a disadvantage. Secondly, the present financing arrangement has worked better for inpatient services than for outpatient services or for non-hospital training sites. As a result, specialties emphasizing inpatient care have been favored over those emphasizing ambulatory care. Training in the surgical specialties has been

advantaged relative to training in general primary care. Third, reimbursed on a cost basis, hospitals have been unable to effectively challenge specialty board efforts to increase the length of residencies and to develop an increasing number of subspecialty programs. Finally, because payroll taxes are used for the Part A trust fund, graduate medical education is supported with a relatively regressive tax.

These strengths and weaknesses of our present system are known. Additional information for use in assessing the present system and alternative arrangements is presently being developed in at least three studies:

- the HHS Assistant Secretary for Planning and Evaluation's study of the Financing of Graduate Medical Education being performed by Arthur Young and Company;
- the Commonwealth Fund Task Force on Academic Medical Centers is preparing an analytical paper on "The Future Financing of Teaching Hospitals" using a secondary analysis of existing data; and
- the Health Care Financing Administration will be preparing four annual reports on the impacts, intended and unintended, of prospective payment on types of hospitals, including teaching hospitals.

In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded. The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and

explore future alternatives for financing residency training. I chair that Committee and its members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the committee were held in November, January and February and alternatives for financing graduate medical education were explored.

The Committee concluded substantial disagreements exist within the medical education community about the most appropriate future policy for financing graduate medical education. Therefore, the Committee has prepared a "Statement of Issues" to use in membership discussions and debates. A copy of that "Statement of Issues" is attached to this testimony. The five primary policy issues set forth for debate in that statement can be summarized as follows:

1) In a price sensitive environment, will teaching hospitals be able to compete successfully for patient care revenues while continuing to support residency training through patient care, or should separate funding mechanisms be established for GME costs?

2) If a separate funding mechanism is established, should the Federal role in such an approach be limited to Medicare and Medicaid patients or should the Federal role be expanded to include full, comprehensive funding of all graduate medical education?

3) Since those who pay for residency training may be interested in curtailing the open-endedness of its funding, is it more appropriate to control the number of years of funding per resident or the number of positions to be funded?

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4) Non-hospital sites are being increasingly used as sites for residency training, particularily for the primary care specialties; how can this change be appropriately recognized in a payment system?

5) What responsibility does the American public have for the residency training of FMGs?

The academic medical and hospital community is not of one mind on the alternatives presented by these questions. Therefore, the AAMC cannot, at this time, present a single series of recommendations for the future financing of graduate medical education.

The Quayle Proposal

In the January 31, 1985 Congressional Record (pp. S963-S965), Senator Quayle made a proposal for changing the conditions under which the financing of graduate medical education would continue under the Medicare program. The AAMC and its members appreciate Senator Quayle's interest in this problem, his recognition that graduate medical education has real costs, and his understanding of the interwoven relationship of residency training and patient services in teaching hospitals. There are, however, a number of issues embedded in the general principles and specific steps about which the AAMC has questions, comments, or concerns.

Principle I: "There should be an opportunity for every graduate of an LCME-approved U.S. medical school to compete successfully for a position in an approved and funded GME program."

The Association has repeatedly emphasized that a contemporary medical education requires the completion of both medical school and residency training. The AAMC believes it would be inappropriate to allow medical school graduates to enter independent practice without completing graduate medical education. At the present, all but seven states require at least one year of GME for licensure and there is an increasing trend to require more than one year of GME for licensure. The AAMC is concerned, however, with the statement "...it is important that the number of first-year training positions offered throughout the country approximate the number of graduates of U.S. LCME-approved medical schools" (empahsis added). First, the AAMC believes there needs to be some flexibility in the system to permit graduates to prepare themselves for careers in those specialties for which they are best suited by their temperament, skills, and interests. Secondly, due consideration must be given to the positions required for the U.S. to meet its responsibilities to educate and train those individuals from other countries who will return to improve the quality of their nation's health care, regardless of how their training is funded.

Principle II: "There is no requirement that each graduate be able to receive training in the specialty of his or her choice."

Each year, some U.S. medical school graduates are unable to obtain a training position in the specialty of their first choice. As long as alternatives are available in which they have interests and capabilities, second or third specialty preferences have been selected. In a society of limited means, this is appropriate. The AAMC would argue that the system should not become so closed or rigid that it forces graduates into training for specialties for which they are ill suited.

Principle III: "Education and patient care are completely interwoven in GME programs. ...[E]ach teaching hospital must have an appropriate affiliation agreement with a U.S. medical school..."

U.S. graduate medical education is recognized throughout the world for its excellence in preparing physicians for clinical practice. This excellence has been achieved by the commitment of its sponsoring institutions and by the long-standing mechanisms of accreditation based on peer review. While the vast majority of residing programs are offered by hospitals having an affiliation agreement with a medical school, there are some high quality programs which are not affiliated with a medical school. Federal legislation should not preclude financial support for these unaffiliated programs at a time when the number of U.S. graduates is only slightly smaller than the number of positions for which they apply.

Step 1. "A larger percentage of graduate physicians should enter training in the primary care specialties of internal medicine, pediatrics, family medicine, and obstetrics/gynecology."

At the present time, almost half of all filled residency positions are in these four primary care specialties. The AAMC Committee on Financing Graduate Medical Education has considered alternatives which would increase the proportion of residents in primary care. Approaches based on both financial incentives and manpower regulation have been considered. The Committee appears to favor increasing the proportion of positions in primary care; however, it has noted three problems. First, new primary care residencies might have to be established in hospitals which are presently either non-teaching or have only a small number

of positions. Given the present debate about payer support of graduate medical education, some of these hospitals are reluctant to launch a new program on an uncertain financial base. Secondly, primary care training grants authorized under Title VII of the Public Health Service Act are eliminated in the President's budget. Present and prospective hospitals with a commitment to primary care training view the proposed elimination of Title VII as a harbinger of things to come. Third, graduate medical education cannot single-handedly change resident preferences, in part because of the well-known income potential and working hours of various specialties. Unless changes are made in payments for physicians' services, increasing primary care training will be handicapped by perceptions of the rewards of different specialties.

Step 2. "Medicare should pay educational costs only when at least 75 percent of trainees in a GME program are graduates of an LCME-approved U.S. medical school."

The AAMC's Committee on Financing Graduate Medical Education believes the primary responsbility of the United States is to support graduates of an LCME-approved U.S. medical school. Therefore, the Association will be considering a recommendation that all positions filled by graduates of LCME-approved U.S. schools be funded and that funding for foreign graduates be supported by mechanisms other than reimbursements for medical care.

Step 3. "...(Require) each teaching hospital that wishes to be eligible for Medicare funds for GME to have an affiliation agreement with a medical school..."

While the most recent data from the American Hospital Association show 924 non-federal community hospitals training 55,913 residents are affiliated with medical schools, the AAMC has reservations about this step. First, affiliation

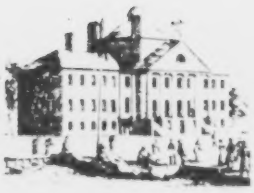
agreements are established primarily for securing clinical resources for the education and training of medical students. Secondly, affiliation agreements are highly varied. Some are quite detailed; others are one page promises to work together. If the provisions of this proposal were enacted into law, regulations would have to be established defining the nature and content of acceptable affiliation agreements. The Association is opposed to Federal intrusion into this area because of the great variation in the affiliations that have provided effective relationships between medical schools and teaching hospitals for a wide variety of education and research programs. The present accreditation procedures can continue to ensure high quality graduate medical education programs. This pluralistic, private sector initiative should be encouraged to continue upgrading graduate medical education.

A Final Comment

It should be recognized that the American system for graduate medical education is grounded in the teaching hospital. Graduate medical education cannot function effectively unless teaching hospitals are compensated for the added costs associated with their responsibilities. For the last two decades, the financing of teaching hospitals has been adequate and stable and permitted the development of high quality GME programs which have trained thousands of competent physicians annually. As medical schools responded to a national policy of increasing physician graduates, hospitals responded by expanding residency training. Now, however, the financial stability of teaching hospitals is at risk. New payment systems being introduced assume that patients with the same illness require the same intensity of care and utilization of resources. This approach does not take into account the generally greater complexity of illness of patients treated in teaching hospitals or the costs of graduate medical education which prepares the next generation of physicians. In a "prudent

buyer," price competitive market, tertiary care/teaching hospitals will fail financially because paying an average price per case does not meet the financial requirements of the teaching hospital's special services. Even a subsidy for graduate medical education will be insufficient if it does not include additional expenses for tertiary care services, stand-by services, new technology, and charity care in addition to graduate medical education.

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If developing national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their multiple responsibilities. The Association is pleased that this Subcommittee and its chairman appear willing to study all of these issues before embracing proposed solutions.



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June 19, 1985

Mary McGrane
Legislative Assistant
Committee on Labor and Human Resources
Employment and Productivity Subcommittee
SD - 428 Senate Office Building
Washington, DC 20510

Dear Ms. McGrane:

Here are my responses to the questions posed by Senator Kennedy. Thank you for your patience.

Sincerely,

J. Robert Buchanan, M.D.
General Director

1. Given the approaching oversupply of physicians in certain specialties as described in the GMENAC Report, and the implications for health care costs, what steps is the AAMC taking to address this problem at the undergraduate medical education level?

While your question appears straightforward, it requires a multifaceted answer. First, I would like to offer some cautions regarding the GMENAC report. There are several reasons to believe the projected physician oversupply in that report is overstated. Secondly, I would like to describe the constraints on the AAMC's ability to restrain the growth of the physician supply in general and the oversubscribed specialties in particular. I also will briefly report on actions taken independently by various medical schools to reduce class size in response to their own concerns. Finally, I wish to make you aware of an action taken by the Liaison Committee on Medical Education which may influence more medical students to pursue careers in the undersubscribed specialties by stimulating better counselling.

The GMENAC report predicted an oversupply of physicians of 70,000 in the year 1990. More recently, the Bureau of Health Manpower predicted the oversupply would be half of that number. Both of these figures may be significantly overstated because they fail to take into account important factors. The supply may be reduced by the changing expectations of physicians regarding decreased work hours, and the increasing numbers of women physicians; demand will probably be expanded by the aging of the population, and new and evolving treatments that will make it possible for physicians to offer definitive care to patients for whom they previously might have provided only palliative care.

However, your question asked what the AAMC was doing at the undergraduate level to address the assumed oversupply of physicians. First, you must recognize that the AAMC exercises no authority over its members in matters such as this. As one of the sponsors of the accrediting agencies for medical education (LCME,

ACGME, AND ACCME), the AAMC is involved with the agencies having regulatory authority over the quality of the educational programs; however, these agencies do not take actions designed just to restrict access to the profession. Even if the AAMC were certain that there would be an undesirable oversupply of physicians, the potential for action by the AAMC would be limited by two factors: (1) the increasing influx of foreign medical graduates, especially U.S. citizens who have attended foreign schools, means the AAMC and its members have only limited control over the number of students seeking a career in medicine in the U.S., and (2) the AAMC's ability to act to restrict the number of matriculants is circumscribed by aggressive efforts of the Federal Trade Commission to apply antitrust law concepts to the medical profession. For example, the FTC already has exerted its influence by subpoenaing the records of the medical specialty societies in search of any activities that might have been interpreted as limiting competition. It also objected to the recognition of the Liaison Committee on Medical Education by the Commissioner of Education as the accrediting body for medical schools because, it argued, the involvement of the American Medical Association and its presumed interest in limiting the number of physicians made the LCME structurally incapable of providing "due process." Any action by the AAMC to reduce medical school class size might be viewed with the same suspicion.

Nonetheless, some U.S. medical schools independently have decided to cut their class size. These decisions may have been prompted by concern over the decreasing size and quality of the applicant pool, cuts in state funding, or a variety of other factors. We do know that the Universities of Indiana, Minnesota, and Mississippi have decreased their classes by 10, 10, and 25, respectively, and another three schools - Duke, Hahneman, and the Medical University of South Carolina - have each decreased their class size by 5.

Finally, the Liaison Committee on Medical Education, which accredits U.S. and Canadian medical schools, has included a new provision for accrediting undergraduate medical education programs in the February, 1985 edition of Functions and Structure of a Medical School. This new standard says, in part, "The faculty and chief academic officer must establish a system to assist students in selecting a future medical career and in developing a strategy for application to residency programs." The Executive Council of the AAMC ratified this change along with other changes to the standards. It is hoped that this requirement will help students fully evaluate the potential for practice in all specialties, including the primary care and undersubscribed specialties and promote rational individual decisions.

2. What do you feel are the relative merits of controlling the number of years of funding per resident versus the number of resident positions?

There are, of course, a number of formulae that could be employed to implement each alternative, and each formula would have potentially different ramifications. Let me try to answer your question by juxtaposing two specific proposals which have been discussed. As the example of a proposal which would control the number of years to be funded, I will use the suggestion that just three years of training be funded for every qualified resident. For the other example, I will use the suggestion to fund residents throughout their training, but to limit the number of residency positions available in each type of specialty by imposing something like the GMENAC projections of specialists that will be needed.

The "fund-three-years" scheme is designed to use economic disincentives to persuade medical center and teaching hospitals executives to offer more positions in the primary care specialties in which board eligibility usually is achieved after the third year. Residents who choose specialities requiring longer

training periods would have to be supported by themselves, physician groups, hospital funds, grants, contracts, or philanthropy. This scheme has the virtue of not requiring governmental regulation to allocate residency positions by state or among specialties.

In addition, fixed year funding may create instability in the training programs. Strong training programs are built over time with stable funding which allows the program to retain highly skilled faculty. Unstable or uncertain financing may thwart efforts to build such programs. Funding residents for fewer years than required to satisfy the educational needs of a specialty may lead to inappropriate efforts to shorten training time, residents dropping out before completion of training, or fee-for-service billing for residents who have not completed their training.

The other option of fixing the number of residency positions to be funded explicitly recognizes the variation in time required to be completely trained in the various specialties and subspecialties. However, it would necessitate the establishment of a manpower planning entity to determine the number of and sites for residency positions by specialty. I am concerned about this option, given the caveats I listed in response to the first question regarding our ability to accurately predict the need for physicians and the questionable ability of any entity to select the most appropriate training sites for each residency.

Rather than either of these solutions, I believe consideration should be given to a plan which would:

- retain some assurances of the quality of the service provided to Medicare beneficiaries by continuing to provide funding at least through initial board eligibility for the specialty of choice;

- o begin to control the total dollars spent on graduate medical education and numbers of positions to be funded by eliminating funding for foreign medical graduates;
- o allow some time for teaching hospitals to adapt to the change in funding policy so they can provide for coverage of their services to their patients;
- o continue to permit medical students to select among the various specialties and program Directors to choose from among the applicants; and
- o permit new program development and new practice sites (e.g., community hospitals, HMOs, practice plans) to emerge.

The Dole/Durenberger/Bentsen bill embodies many of these traits, I believe, and therefore while the AAMC raised some concerns during its testimony in front of Senator Durenberger's Subcommittee, it was generally supportive of the bill. I have enclosed a copy of the written testimony offered at that hearing for your information.

3. Do you have thoughts on how it might be possible to control the number of or reapportion residency positions without undermining service needs?

Implicit in your question is the assumption that in controlling the number or reapportioning residency positions, some currently filled and funded residency positions would cease to exist, and therefore an alternative mechanism would have to be found to fulfill the care needs of the patients. Residents provide a wide variety of services to patients, which vary depending on the resident's specialty, skills, year of training, the availability of other personnel, and the

policies of the hospital. In some locations, if the number of residents on duty were decreased, the hospital would be able to recruit young, fully-trained physicians; physicians assistants; nurses or nurse practitioners; and other personnel necessary to provide services to its patients. It should be noted, however, that the total cost to Medicare for replacing the residents, including the physician's fee-for-service billings, may be greater than the current expenditures on graduate medical education. For example, paying for a fully trained physician to assist in surgery may prove more costly than the surgical residents.

However, in other locations, typically some inner city locations, it will be difficult, if not impossible for the hospital to attract and retain such personnel. I have no creative solution for this perplexing problem. It might be possible for some of these hospitals to upgrade the quality of their residency programs to a point where they can attract funded residents, thus shifting the problem of how to service patients needs to some other hospital. Some of the hospitals may be able to draw more heavily upon city, county, or state funds to finance and recruit the needed replacement personnel, but they may have to pay a premium price. Other hospitals may be forced to reassess the services they offer and to eliminate the provision of certain services. For example, if a hospital-run, free-standing satetite clinic had been staffed chiefly by residents, then it might choose to close the clinic, but continue to provide primary care services in its outpatient clinics. I'm sure that a variety of such strategies will be employed by hospitals in which the size of the residency programs is cut.

aamc association of american medical colleges

AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

Statement of Issues

March, 1985

one dupont circle, n.w./washington, d.c. 20036

In the last five years, the AAMC has completed comprehensive reviews of both graduate and undergraduate medical education.* Among the common themes of these reports is the conclusion that a contemporary medical education requires completion of both medical school and residency training in order to be prepared for independent medical practice. Medical schools provide the general professional education which is the foundation of all medical practice. Residency training or graduate medical education provides the formal clinical education that develops the skills and experience necessary for independent practice. Residency programs are accredited by the Residency Review Committees under the supervision of the Accreditation Council for Graduate Medical Education.

Graduate medical education is not focused on the university campus. It takes place primarily in teaching hospitals. Residents, working under supervision, learn clinical medicine by hands-on participation in the care of hospital patients. Patients are being treated and residents are being trained through the same activities. In effect, both products -- patient care and education -- are being simultaneously, or jointly, produced in the teaching hospital.

The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs -- education is not simply a by-product. Adding the educational role involves additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. These costs are real. If graduate medical education is to continue, these costs cannot be avoided. Therefore, the growing debate about financing graduate medical education should

*Graduate Medical Education: Proposals for the Eighties (1981) and Physicians for the Twenty-First Century (1984).

not be one about paying or not paying these costs. Rather, the debate should be about the most appropriate method of paying for the costs of residency training.

For the past several decades, the teaching hospital's added costs for residency training have been financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984 survey of stipends paid to housestaff show 81% of the stipends and benefits are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes patient service revenue has been and continues to be the primary source for supporting the total costs of graduate medical education.

The AAMC has had a long-standing policy on financing graduate medical education which was reaffirmed in 1980 when the AAMC published the report of its Task Force on Graduate Medical Education. This three-year task force recommended that:

> Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospital (p. 94, emphasis added).

The recommendation was consistent with private payer practices and with Congressional intent for the Medicare program. Many Blue Cross agreements throughout the country explictly provide for payment of these costs. Congress clearly established payments for residents in training as a legitimate Part A Medicare expense in the original Medicare statute.

The AAMC continues to believe patient charges and reimbursements are an appropriate method of financing graduate medical education. In fact, if all, or most, of the nation's hospitals participated in graduate medical education, patient service financing of residency training could survive in the face of the increasingly competitive hospital marketplace. However, only 2 percent (125) of the nation's 5,900 community general hospitals provide 50 percent of the nation's residency training. Another 1,100 hospitals provide the remaining half of residency training. These 1,225 hospitals bear the cost of training the nation's entire supply of residents. The remaining 4,600 community hospitals -- as well as health maintenance organizations, competitive medical plans, and preferred provider organizations -- obtain the benefits of fully trained physicians without sharing in the cost of the training itself. This gives the non-teaching hospital an advantage in setting its charges and negotiating contracts. In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded.

The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and explore future alternatives for financing residency training. The Committee is chaired by J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and the members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the Committee were held in November, January and February and alternatives for financing graduate medical

education were explored. This paper has been prepared to summarize the discussions of the Committee and to explain the competing views on the issues of financing graduate medical education reviewed by the Committee.

The Committee's discussions have focused on five topics:

- the need for special funding for graduate medical education in the patient care payment environment that is evolving;
- the advisability of creating a societal funding mechanism for graduate medical education rather than having each payer establish its own policies;
- the number of training years to be financed with any separate funding and the resulting manpower controls that accompany various alternatives;
- the increasing use of non-hospital sites, especially ambulatory care settings, for residency training; and
- the responsibility for training physicians educated in foreign medical schools.

The remainder of this report explores each of these topics in some detail in order to provide AAMC members, physicians and hospitals, third party payers, and public policy analysts with an understanding of the conflicting viewpoints within the medical education community.

The Need for Separate Funding

Patient care financing of graduate medical education has well served teaching hospitals, physicians-in-training, and society for several decades. Hospitals have been able to expand positions available to meet the increasing number of medical school graduates, specialties have upgraded their basic clinical training requirements, new subspecialties in medicine and surgery have developed, and new technologies have been widely disseminated.

Some Committee members and some AAMC members believe that teaching hospitals may be able to compete in the new environment without separate funding for the higher costs that result from graduate medical education. Until evidence to the contrary is clear, they believe that it would be unwise for the AAMC to advocate alternate financing arrangements which may jeopardize some of the benefits of the current system. These benefits include the freedom of medical students to elect to train in the specialty of their choice and the ability of teaching hospitals to offer a variety of residency programs.

The competing view, held by the majority of the Committee and many AAMC members, is that patient revenues in the future price-competitive market may be insufficient to support financing of graduate medical education and that alternatives must be found or at least explored. This group believes payers will withdraw their explicit support and/or cut back on their implicit support for graduate medical education. As a result, teaching hospitals will be forced either to limit other hospital programs and services to support the educational mission or to reduce the numbers of residents and faculty they support. Other missions also may increasingly draw on the resources of the teaching hospitals. For example, many teaching hospitals are being asked to provide increasing amounts of care to the indigent without concommitant increases in state or local

support. Thus, institutional resources are being stretched substantially and may be unable to support educational programs at current levels.

In substantial part, this dichotomy of viewpoints reflects different member experiences and points of reference. Those who advocate continuing to finance graduate medical education with patient service revenues present their viewpoint with reference to a payment system based on negotiated prices. They believe the teaching hospital has a marketable resource in its educational activities. They see education providing a quality-enhancing benefit not available from non-teaching hospitals. Moreover, in a negotiated market, a hospital is free to reject a price which does not enable it to meet its patient care and educational costs.

Those who advocate establishing separate financing for graduate medical education present their view with reference to a payment system based either on administered prices set by an external entity or on a payment system dominated simply by lowest price. For example, Medicare's basic prospective payment formulas are designed to pay a fixed price for a given patient irrespective of whether the hospital does or does not offer residency training. Unless separate funding is added, such as Medicare's current medical education passthrough, the teaching hospital must provide two products (i.e., patient care and education) for the same price the non-teaching hospital must provide only patient care. For non-Medicare payers, if price is the only selection criteria, there will not be additional funding for graduate medical education.

Given these differing reference points and perspectives, the AAMC faces two fundamental but conflicting assumptions:

> public and private payers will recognize the unique contributions and benefits of teaching hospitals and be willing to pay teaching hospitals higher payments. As a result, the AAMC need not explore alternative arrangements for financing graduate medical education;
>
> 6

or

> public and private payers of hospital services are becoming increasingly resistant to including adequate funding for the support of graduate medical education in their general patient care payments. As a result, the AAMC must explore options to provide support for this essential mission of teaching hospitals.

Resolution of this fundamental difference in working assumptions must precede discussions about the methodologies and structures for financing graduate medical education.

The Committee premised its development of alternative financing arrangements on the latter assumption cited above. This does not imply that it is inappropriate to finance GME with the general operating revenues of teaching hospitals. It does recognize, however, that in the future new payment systems for patient services may not provide teaching hospitals with sufficient funds to finance both their patient care and educational missions. Therefore, the Committee has explored alternatives and identified conflicting issues that must be resolved.

Scope of Proposals

Health care financing arrangements, both public and private, are undergoing substantial changes:

- payers are increasingly interested in paying only for the immediate services used by their beneficiaries,
- predetermined payments are replacing retrospective cost reimbursement, and
- low price is replacing access as a criteria for selecting hospitals.

In this environment, each payer has an economic advantage in behaving as a marginal price purchaser paying only the incremental costs arising from services provided to its patients. This behavioral incentive, however, is in conflict with the broader societal interest in maintaining and supporting commonweal services benefiting all collectively but no payer individually.

Adequate financing for graduate medical education requires each payer to subordinate some of its economic self-interest to the broader social interest of adequately training new physicians. This subordination of self interest can be achieved in two ways: (1) society can impose a tax to support the costs of residency training or (2) payers can individually be persuaded for social, ethical, or public image reasons to share in financing residency training.

The Committee recognizes advantages and disadvantages to each approach. The taxation approach is the most likely to provide comprehensive financing and to avoid conflicting health manpower policies across payers. However, requiring a Federal tax, administered by Federal officials, seems to be contradictory to the present political climate. Morover, it would make residency training dependent on a single source of funds and subject it to annual debates in the Federal budget. Such fiscal control could lead to massive intervention in medical education. Similar reservations exist for state-administered taxes. In addition, a state tax approach could lead to conflicting manpower policies across the nation.

The individual payer approach does not require major Federal legislation or a new bureaucracy and it permits manpower training decisions to remain at the institutional level. It is not clear, however, whether payers will subordinate their economic self interest. Some may; others may not. As a result, the revenue base for residency training may be incomplete and constantly changing.

The preferred course is unclear. Should the AAMC seek a comprehensive, national tax or should the AAMC concentrate on national payers (e.g., Medicare) while individual members work with their state and with individual payers? Each choice has major risks.

The Training Period To Be Funded

If separate funding is provided to support graduate medical education, the amount of that funding could be set by determining the number of residents to be financed and the number of training years to be supported. Three options on the length of training which would be supported by separate funding are available: (1) fund residents for a fixed number of years (e.g., 3, 4, or 5) regardless of the specialty in which the resident is training; (2) fund residents only for the period of time necessary to obtain initial board eligibility; or (3) fund residents in all accredited programs for initial and subspecialty training.

Option one provides separate funding for a fixed number of years per resident. Residents in programs which can be completed in the fixed number of years are supported throughout their training. Residents in the longer programs would receive funding for the fixed number of years but they, the hospital and the staff physicians would have to support the remaining years with patient service revenues, grants, appropriations, contracts, or philanthropy. For example, if the separate funding were provided for the first three years of residency training, residents in three year programs would be supported for all training years. Residents in programs lasting four or more years would receive separate funding only for the first three years of their program. Thus, under the three year example, residents in family practice, pediatrics, and internal medicine would receive funding throughout their basic training. Residents in all other specialties and subspecialties would receive funding only for the first three years of their program. Advocates of fixed year funding emphasize two

advantages to the approach. First, it minimizes external regulation. It does not require an external entity to allocate residency positions by specialty or across hospitals because payment is made based solely on the number of residents at or below the fixed years of training. Secondly, the advocates generally believe it will increase the proportion of residents training in the primary care specialties and decrease the proportion of residents undertaking subspecialty training. Detractors are concerned that the fixed year funding creates instability and uncertainty for residency programs lasting beyond the fixed year threshold. They note that strong training programs are built across time and need stability of financing and personnel. Detractors are also concerned that funding less than the years required for certification may lead to: inappropriate efforts to shorten training time, residents who drop out of training programs before completing them, or fee-for-service billing for residents who have not completed their training programs.

A second alternative varies the number of years of separate funding with the number of years of specialty training required for initial board certification. Residents in internal medicine would be supported for the three years of internal medicine with no separate funding provided for subspecialty training. Residents in surgery would be supported for the five years required for general surgery with no additional separate funding provided for the extra years required for thoracic, plastic, or colon and rectal surgery. The principal advantage of this alternative is its explicit recognition of the variation in the time required for initial board certification in different specialties. Some Committee members are concerned that separate funding which varies with the training required for initial board eligibility may lead to the development of a manpower planning entity which designates the number of approved positions in each specialty. The majority of the Committee believes, however, that a manpower planning entity is not necessary if separate funding is limited to the initial training program.

The majority also believes their position would be strengthened if the number of years of support for each specialty is limited to the present requirement. The major disadvantage of this alternative is its limitation to initial board eligibility. In many specialties -- including internal medicine, pediatrics, and surgery -- some residents undertake subspecialty training after they have completed, or could have completed, the initial residency. This alternative would not provide separate funding for residents in subspecialty training. Other sources of financing would be needed to support subspecialty programs.

The third alternative provides separate funding for all residents training in approved training programs. This approach provides separate funding for full specialty and subspecialty training in all disciplines. Advocates of this approach emphasize that it provides full funding for the period of time that the physician-in-training is subject to the direction and supervision of faculty. It does not provide an economic disincentive to developing or pursuing the longer training programs. Detractors note the open-endedness of this approach. They believe the funding entity is likely to limit its financial exposure under this option by developing explicit manpower training policies. The detractors are concerned that some entity may determine how many positions in each type of training will be offered and which hospitals will be approved for funding.

The three funding options are dramatically different. They vary in terms of ease of administration, financial comprehensiveness, and likely manpower regulation. Each approach has supporters. Selection of any one approach will bring fundamental change to residency training.

Non-Hospital Training Sites

Increasingly, acute care hospitals are being used only for the most intensive portion of a patient's illness or procedure. This has changed both the kinds of cases admitted to inpatient units and shortened the length of time the patient is in the hospital. As a result, several specialties are are now trying to incorporate non-hospital experiences in their residency programs. This creates problems because hospital patient care revenue has been the predominate source of support for residency training. While hospital charges and costs presently include expenses for graduate medical education programs, ambulatory care providers do not have such costs in their present charges. Increasing charges in ambulatory or long-term care settings to support residency training would disadvantage some providers as price competition in all areas of medical care increases. Innovative financing approaches must be developed and evaluated for both long-term care and ambulatory settings.

Residency Positions To Be Supported

The United States has 127 medical schools accredited by the Liaison Committee on Medical Education (LCME) and 15 accredited osteopathic schools from which there are a total of approximately 16,200 graduates. The AAMC Committee believes that the United States has an obligation to provide the resources necessary to train these graduates. The Committee believes society has no similar obligation to provide and financially underwrite graduate medical education for graduates of non-accredited medical schools or schools outside the U.S. At the present time 18% of residency training positions are occupied by physicians graduating from foreign medical schools. While some U.S. hospitals may wish to continue training foreign graduates, the Committee believes such training need not be supported by funding arrangements designed to support graduate medical education. Because almost twenty percent of current residents

are foreign medical graduates, adoption by payers of the Committee's position would substantially reduce the funding needed for graduate medical education.

Conclusion

This statement of issues is focused on five major topics surrounding the future financing of graduate medical education. The Committee recognizes that numerous secondary issues have not been addressed. For example, approaches which increase the uncertainty of residency support may discourage economically-disadvantaged individuals from choosing a medical career. Eliminating funding for foreign medical graduates may pose special transition problems for patient services in some hospitals. The Committee is aware of these and other secondary concerns but chose to omit them in order to address the primary topics in a more tightly focused way.

During the last two decades, hospitals have operated for the most part in a cost reimbursement era with substantial autonomy. They have competed with each other on the basis of quality and scope of services; there was minimal competition on the basis of price. The Committee recognizes that the environment of the mid-80's and beyond is different and that hospitals must improve the efficiency of all their services. Price per unit of service is becoming the basis of competition. Even efficient teaching hospitals are disadvantaged in the price competitive market for a variety of reasons including:

- o the provision of a disproportionately large share of care to the indigent;
- o the treatment of the most severely ill patients;

- the provision of regional stand-by services, such as burn centers, pediatric and adult open-heart surgery centers, and transplant centers;
- the presence of clinical research efforts to advance diagnostic and treatment capabilities; and
- the provision of graduate medical education to maintain the supply of physicians for this country.

All of these functions are important to the missions of teaching hospitals, and all make teaching hospitals more expensive to operate than non-teaching hospitals. The Committee's task is to examine only changes in the financing of graduate medical education, but it clearly recognizes that even if separate funding for graduate medical education is adopted, teaching hospitals will continue to require special consideration in any hospital financing scheme for the other functions that distinguish them from non-teaching hospitals. While financial support for graduate medical education will not eliminate the teaching hospital's problems, support for GME will contribute to a more equitable market in which teaching hospitals are less disadvantaged.

Attachment A

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THE MEDICARE ADJUSTMENT FOR THE INDIRECT COSTS OF MEDICAL EDUCATION: HISTORICAL DEVELOPMENT AND CURRENT STATUS

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University of Pittsburgh
January, 1985

This report was prepared under a contract with the Association of American Medical Colleges. I would like to thank James Bentley, Richard Knapp, Julian Pettengill and Lester Lave for comments and criticisms on earlier drafts. I alone am responsible for the interpretation and conclusions.

PREFACE

An integral part of the recently enacted Medicare Prospective Payment System is the "indirect medical education adjustment," yet there is a great deal of misunderstanding concerning the purpose of this adjustment. Its title has led many to believe that this adjustment to the DRG prices is to compensate for education and related program costs. However, its congressional sponsors and the AAMC have recognized from the beginning that these payments are in fact necessary to recognize the costs of tertiary care and the unique services which are most commonly provided in teaching hospitals, and the limitations of the Diagnosis Related Groups as a unit of payment.

In order to clarify the intent of this "indirect medical education adjustment," the AAMC contracted with Judith Lave, Ph.D., Professor of Health Economics at the University of Pittsburgh and former director of the Office of Research within the Health Care Financing Administration, to write her perceptions of the history and purposes of the indirect medical education adjustment.

I believe Dr. Lave has done an excellent job and provided a document which gives a thorough and thoughtful account of the development and intentions of this adjustment. I believe the document is worth your attention.

John A. D. Cooper, M.D.

EXECUTIVE SUMMARY

The concept of the indirect costs of medical education was introduced into the hospital payment lexicon in 1980 by the Health Care Financing Administration (HCFA). HCFA stated that in calculating the then "Section 223" cost limits, per diem allowable costs could be adjusted for a number of factors including the number of residents per bed. The "medical education" adjustment was included to account for the increase in per diem costs found to be associated with the number of residents per bed.

Since then, Medicare's reimbursement policy has been fundamentally changed. Retrospective cost based reimbursement is being supplanted by a prospective payment system. Under the fully implemented Medicare Prospective Payment System (PPS), Medicare's share of capital and direct graduate medical education costs still will be paid on the basis of reimbursable costs while prospectively set DRG payments will cover Medicare's share of hospital operating costs. In addition to the standard DRG payments and the cost reimbursed passthroughs, teaching hospitals will receive incremental payments tied to the number of residents per bed. These payments, which have become known as payments to cover the indirect costs of medical education, will account for approximately 5.5 percent of total Medicare payments under the fully implemented PPS system.

In the following overview, the concept of indirect medical education adjustment is discussed first. Next the approach used by HCFA to estimate this adjustment is outlined. Third the factors leading up to the doubling of the HCFA estimated adjustment and the implications of the doubling are discussed.

The size of payments made under the rubric "payments to cover the cost of medical education" makes the adjustment an easy target for budget cuts. However, if these payments are to be cut it is necessary that accompanying changes be made in PPS. Therefore, the paper concludes by describing changes which would enhance the equity and efficiency of PPS not only for teaching hospitals, but all hospitals and patients, including:

- recategorization of some of the more heterogeneous DRGs,
- improvements in the setting of the DRG relative prices,
- determination of improved wage indices,
- reassessment of the definition of the market for which factor price differences will be taken into consideration, and
- reconsideration of the number of locational factors that will be used in adjusting the standardized DRG rates for different hospitals.

Some of the changes, such as the DRG classification system, HCFA already has under examination. Others, such as a reconsideration of the market areas, have been virtually ignored. All, however, are of vital importance if the PPS is to provide the equity across hospitals that is required for a long term payment reform.

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Introduction

On April 1, 1980, a proposed rule (NPRM) in the Federal Register introduced a new concept into the hospital payment lexicon: the adjustment for the indirect costs of medical education. In setting the proposed schedule of limits for hospital inpatient general routine operating costs for cost reporting periods beginning on or after July 1, 1980, the Health Care Financing Administration (HCFA) stated that Medicare allowable costs could be adjusted for differences among hospitals in location (urban/rural), area wage rates, bed size, and the number of interns and residents per bed. The adjustment for the number of interns and residents per bed was included to account for the increased per diem costs "due to approved medical education programs".[1]

Since then, Medicare hospital reimbursement policy has been fundamentally changed: retrospective, cost based reimbursement is being replaced by a prospective payment system. The new system includes explicit additional payments to teaching hospitals. These payments, which are also directly related to the number of interns and residents per bed, are described in the implementing regulations as compensation for the "indirect costs" of education. These payments will account for approximately 5.5 percent of total Medicare payments for hospitals under the fully implemented prospective payment system.[2]

Now under the pressure of large and persistent federal budget deficits, the social policy of subsidizing graduate medical education through increased payments for patient care is increasingly open to question. In addition, given the "budget neutrality" of the new system more payments to hospitals with large graduate medical education programs means lower payments for those hospitals with none. Some have argued that the additional payments to teaching hospitals are unfair as they reward uneconomic behavior in those hospitals. The teaching hospitals, however, stress that their higher costs are related to legitimate differences in other factors associated with teaching programs, such as the severity of illness, that make their patients more expensive to treat. Thus, they maintain these extra payments should not be described as subsidies for teaching but as legitimate payments in recognition of other factors not adequately accounted for in the new system.

Given the magnitude of the payments resulting from the resident to bed adjustment, it is important to understand its origin and evolution. This paper begins with a brief discussion of the background events leading up to the introduction of the resident to bed adjustment in 1980. Next, it describes how the adjustment was incorporated into the new Medicare hospital prospective payment system. It then goes on to examine the factors that contribute to the observed relationship between the number of residents per bed and Medicare operating costs per case. This section sets the basis for a consideration of the factors that must be explicitly considered as the prospective payment system evolves.

Background to the April 1, 1980 NPRM

Section 223 of the Social Security Amendments of 1972 authorized the Secretary of Health, Education and Welfare to set prospective limits on the amount of costs authorized for reimbursement to institutional providers under Part A of Medicare. These limits were to be based on the estimated costs necessary to provide needed services efficiently. Such estimates, however, are extraordinarily difficult to make. Given the limitations of data and methods at that time, early efforts to implement this provision focused on setting limits on hospital routine per diem costs. Routine per diem costs sufficiently above the costs of comparable hospitals were considered unreasonable and therefore not reimbursable.

Between 1974, when the regulations implementing the legislation were first published, and 1980 the methods used to establish the limits were changed in a number of ways. These changes stemmed from three interacting conditions: (1) improvements in the Federal government's ability to classify hospitals and thus to compare hospital costs, (2) a steady lowering of limits due to the improvement in classification systems and increasing pressure for Federal budget savings, and (3) revision of the methods to compare costs to respond to the needs of groups of institutions which were disproportionately affected by the lowering of the limits.

For the purpose of this paper, one such change should be noted. In 1979 it was decided that in calculating its routine per diem costs, a hospital could exclude all direct teaching costs. The direct costs for teaching were excluded because it did not seem fair to compare the routine per diem costs of nonteaching hospitals to those of teaching hospitals if the direct costs of teaching were included. The costs of teaching hospitals would surely be higher. This exclusion set a precedent for separating out direct teaching costs, a separation that carried over into the design of the Medicare Prospective Payment System.

By 1979, the cost limits were set at the 80th percentile of the costs of comparable hospitals; and the hospital size, location (urban/rural) and area wage rates were taken into consideration in determining comparability among hospitals. The Administration intended to lower the Section 223 limits further. However, any significant reduction in the limits would have hurt many hospitals, and, without any change in the grouping methodology, it would have had a particularly severe impact on teaching hospitals, especially those with very large graduate medical education programs. Thus political pressure was put on the Department of Health and Human Services (the successor of the Department of Health, Education and

Welfare) to take the special circumstances of the teaching hospitals into account.

Two options were considered to adjust for the higher costs of teaching hospitals. The first option was to create special groups of teaching hospitals. Grouping variables considered included: nature of affiliation with a medical school, the number of approved residency programs and the number of interns and residents (hereafter residents) per bed. However, data analysis did not reveal any obvious groups; for example, there were no clear cut breaks in the distribution of the number of residents per bed. Thus any effort to form groups would have created a significant boundary problem. The second option was to use a continuous adjustment procedure. Statistical analysis suggested that, after controlling for bed size, location and area wages, routine costs per day in teaching hospitals increased on average 4.7 percent with every .1 resident per bed. This empirical relationship could be used to adjust a hospital's limit.

The Office of Research in HCFA recommended application of this teaching adjustment factor (to the limit that otherwise would have been set on the basis of bed size, wage level and location) in determining the routine cost limits for teaching hospitals. At the same time it acknowledged that, despite this observed relationship, the specific cost elements increased by the level of teaching activity were not identified.[3] The recommendation to use a resident to bed adjustment was accepted, but not without discussion. There was some concern expressed within HCFA that the higher costs of teaching hospitals were due to lower levels of productivity and that pressure should be placed on these institutions to become more efficient. In addition, there was some concern that this adjustment might lead to an expansion in the number of residency programs.

The April 1980 NPRM and the June 1980 final rule made a number of changes in prior regulations: they lowered the limit from the 80th percentile of the cost distribution of comparable hospitals to 112 percent of the mean and they provided for an adjustment in the limit depending on the number of residents per bed. An explanation of the adjustment for the allowed higher costs for teaching hospitals was given in the April NPRM.[4]

> *We believe these increases in per diem costs occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. For example, a hospital with an approved medical education program may be required, for training purposes, to maintain more detailed and complete medical records than a nonteaching hospital. However, medical records are not considered educational expenses and, therefore, are not excluded from the costs subject to the limitation under the current schedule.*

Thus, this adjustment was clearly labelled an adjustment for the *indirect* costs associated with medical education programs.

The Adjustment for Medical Education Under Prospective Payment

Between 1980, when the resident to bed adjustment to the limits was adopted, and 1983 when the prospective payment legislation (PL-98-21) was passed, the approach taken to adjust for the higher costs of teaching hospitals remained unchanged. While the 223 routine cost limits were in effect, the 4.7 percent adjustment for the indirect costs of medical education continued. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made fundamental changes in the way that hospitals were reimbursed under Medicare—it extended the 223 limits to cover total operating costs per discharge and it set a limit on the allowable rate of increase in operating costs per case. Nevertheless, the method used to set the total operating cost limits for teaching hospitals paralleled that for the routine cost limits—the limit was adjusted upwards with the number of residents per bed and the magnitude of the percentage adjustment was determined by a statistical analysis similar to one used to set the adjustment to the routine limits.

The TEFRA legislation directed the Secretary of Health and Human Services to report back to the Congress by December 1982 on a method to set prospective payments for hospitals under Medicare. In designing the new system, the Secretary made an early policy decision that Medicare would pay a single price for a given product. The issues of the teaching hospitals and methods to pay for graduate medical education were reopened and alternatives to the current adjustment procedures were explored.[5] The decisions reached were laid out in the Report to the Congress.

The first major decision had to do with paying for the direct costs of teaching.[6]

> *The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.*

The second major decision had to do with the indirect costs of teaching:[7]

> *The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more*

tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.

It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.

The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.

The Secretary's proposal established a fee schedule for hospital services. The Diagnosis Related Groups, the DRGs, were the recommended unit of payment and the prices set for the DRGs were based on an estimate of the average cost of each DRG. The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries. DRG prices would vary with hospital wages in the area, hospital location (urban/rural) and the extent of teaching. (Although the actual payment for the indirect teaching adjustment is to be made as a lump sum, it is useful for discussion purposes to think of it as an adjustment to the rate). The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries.

The Secretary originally proposed that after adjusting for hospital wages and location, the DRG payment should increase by 5.79 percent for each .1 increase in the number of residents per bed. As before, this adjustment factor had been estimated statistically. However, in this case, there was a difference between the factors that were controlled for in estimating the adjustment factor and those factors the Secretary recommended be taken into consideration in setting the rate. This point, which is very important, is further developed below.

In determining the statistical relationship between hospital operating costs per discharge and residents per bed, analysts controlled for hospital case mix, area wages, bed size, and the size of the geographic area in which the hospital was located.[4] The statistical results indicated that controlling for the other factors included in the analysis, the Medicare operating cost per case increased approximately 5.79 percent with every .1 increase in the number of residents per bed. The analysis also indicated that Medicare costs increased with hospital bed size and that the costs of hospitals located in Metropolitan Statistical Areas (MSAs) with over a million population were much higher than those in rural or in smaller urban areas. Thus, the Secretary's decision to vary the price paid for each DRG only with the hospital's case mix, residents per bed, area wage level and location (based on a simple urban/rural split) meant that *large* hospitals located in *large urban* areas would be relatively adversely affected by the payment system. These characteristics, however, are exactly the characteristics of hospitals with large graduate medical education programs. Of the 329 non-federal hospitals that are Council of Teaching Hospitals (COTH) member hospitals, 74 percent have more than 399 beds (compared to 7 percent of the 5,655 nonmember hospitals), and 61 percent are in urban areas with populations of 1,000,000 or more (compared to 23 percent of nonmember hospitals).

The extent to which certain types of hospitals would be adversely affected by the proposed system, was vividly indicated in an impact analysis prepared by the Congressional Budget Office (CBO). CBO presented preliminary information on the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. These estimates are presented in Table I. Here it is shown that 70 percent of the hospitals with over 300 beds, 57 percent of urban hospitals and 71 percent of teaching hospitals would be adversely affected.

The negative effect of the proposed system on the nation's teaching hospitals was larger than was desirable or politically tolerable. In response to this problem, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services suggested that the adjustment for medical education be doubled from 5.79 (the original proposal) to 11.59 percent for each .1 increase in the resident to bed ratio. This was an expedient proposal which, as will be argued below, temporarily "solved" the problem of the teaching hospitals without addressing a major source of the problem, that is, that the Secretary's proposal did not adjust adequately for the differences in the market areas in which those hospitals were located.

Before passing the prospective payment legislation, the Congress accepted the suggestion of the Assistant Secretary and made several other changes to the Secretary's proposed plan. The most important of these was the introduction of a phase-in period during which the DRG prices paid to a given hospital would move from being based almost entirely on its own historical operating costs to being based on the average costs in urban or rural areas; that is, to move from a hospital specific rate to a national urban or rural rate. Under the fully implemented system, these

Table 1
Estimated Average Penalties and Bonuses Under the Administration's Proposed DRG-Based Payment System By Type of Hospital[a]

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[b]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[c]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[d]
All Hospitals	100	0[e]	61	+23	39	−12
Bed Size						
Less than 100	49	+23	80	+35	20	−10
100–299	34	+2	50	+21	50	−11
300+	17	−6	30	+17	70	−13
SMSA						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13
Teaching Status						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

b. Average calculated for all hospitals.

c. Average calculated for hospitals that would gain.

d. Average calculated for hospitals that would lose.

e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives, February 14, 1983.

rates would vary only with those factors recommended by the Secretary, the resident to bed ratio and area wage rates. However, both the House and the Senate in their committee reports commented on the increased resident to bed adjustment. The Senate stated:[9]

> *This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.*

The regulations implementing this legislation made the following statement with respect to the resident to bed adjustment:[10]

> *Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education.*

This cryptic comment could imply that the Department views the additional payment as primarily an additional outlay to cover the indirect costs of medical education and not to compensate for the weaknesses in the DRG system.

At this point, however, it is useful to leave the legislative and regulatory environment and to consider the adjustment, and what it represents, in more detail.

The Indirect Teaching Factor: What Does It Really Measure?

Nationally, the observed operating costs of hospitals with large graduate medical education programs are considerably higher than those without such programs. The important question is why are their costs higher? Are the costs of teaching hospitals higher because these hospitals treat sicker and more complicated patients who are more costly to treat? Are the costs of these hospitals higher because they tend to be located in the central cities of large metropolitan areas where it is more expensive to provide hospital services, or are their operating costs higher because it is more costly to treat patients in these hospitals? In this section these issues are addressed.

A preliminary answer to these questions is given by reexamining the results of the statistical analysis done by HCFA.[11] HCFA analysts studied the factors associated with Medicare costs per case. They ascertained that costs rose proportionately with the Medicare Case Mix Index (a measure of the costliness of a hospital's case mix as measured by DRGs) and the average wages paid to hospital employees in the SMSA in which the hospital was located. They also determined (other things being equal) that relative to hospitals located in rural areas, hospital costs in urban areas with less than 250,000 people were only slightly more costly, that hospitals located in areas with between 250,000 to a million people were 2.6 percent more costly and those located in areas with over a million population were 10.9 percent more costly. They determined that costs increased, but less than proportionately, with hospital bed size. Since major teaching hospitals have higher measured case mix indices, are located in SMSA's with high wage rates, are located in the largest metropolitan areas and are bigger, these factors will account for much of the higher observed Medicare operating costs per case in these hospitals.

Nevertheless, controlling for these factors, Medicare operating costs per case increased approximately 5.79 percent for each .1 increase in the number of residents per bed and it is this relationship that has been labelled the indirect cost of teaching.

Before continuing, it is necessary to stress that the estimate of the "indirect costs of teaching" is obtained statistically. The estimated relationship between Medicare operating costs and residents per bed will depend on what other factors are controlled for and how well they are measured. It is likely that some of the effect on costs attributed by the statistical analysis to residents is due to other variables which are not included in the analysis.[12] One indicator of the sensitivity of the estimated size of the indirect teaching adjustments to the nature of the control variables can be given here. If the analysis of Medicare operating cost per case is repeated excluding bed size and SMSA size as control variables and using a simple urban/rural split, then the estimated relationship between costs and each .1 increase in residents per bed increases from 5.79 to about 9 percent. Some of the factors that may cause the measured association between operating costs and residents to be biased upwards are now examined.

1. **Errors in the DRGs.** The Medicare Case Mix Index used in the analysis was based on data that had been reported to HCFA in 1981—the 1981 MedPAR file. The diagnostic information reported to HCFA was often flawed,[13] and research by Pettengill and Vertrees indicates that errors in patient classification tend to compress the estimated values of the individual hospital case mix indices.[14] Thus the measured index of a hospital with a costly case mix is likely to be too low relative to its true value while the measured index of a hospital with a much less costly mix of patients will be too high. If the case mix indices of the teaching hospitals, particularly those with large teaching programs were underestimated, then some of the effect on operating costs that was in fact due to case-mix would be attributed to the resident to bed ratio.

It appears in fact that the case mix indices of many

of the large teaching hospitals were underestimated.[15] Hence, if the analysis were to be repeated today, using more accurate data, the estimated statistical association between Medicare operating costs and the resident to bed ratio should decrease.

2. **DRG prices:** The current set of DRG prices (or relative cost weights) are derived using an algorithm developed by HCFA. To set prices, HCFA estimated the average cost of each DRG by adjusting the average billed charge for each DRG with information from the hospital cost reports. Essentially ancillary costs were distributed across the DRGs on the basis of charges adjusted by departmental cost to charge ratios, and routine and special care costs by their length of stay. The data bases used to calculate these prices were the 1980 Medpar File and the 1980 Medicare Cost Reports.

It is very likely that the relative prices calculated by HCFA are compressed. In other words, the prices of the high cost DRGs are low relative to the actual cost while those of the low cost DRGs are likely to be overpriced.[16] Three factors contribute to this compression. First, there is, as noted above, significant error in the MedPAR data base—thus the estimated cost of a given DRG will be based on patient charges for both patients who are accurately coded in a DRG and those who are inaccurately coded. Second, the price setting algorithm implicitly assumes that the per diem routine costs and per diem special care costs are the same for each DRG. However, to the extent that the level of routine and special care costs are affected by case-mix, this algorithm will lead to a relative underpricing of the high cost DRGs (and overpricing of the low cost ones).[17] Finally, there is considerable anecdotal evidence that, at least until recently, hospitals subsidized the prices of specialized high cost procedures.[18] To the extent this practice is pervasive, the adjusted cost for the truly high cost patients who are likely to use high cost services will be set relatively low.

The compression of the DRG prices will lead to an underestimation of the size of the case-mix index in hospitals that treat a high proportion of high cost patients while it will lead to an overestimation of the size of the case mix index in hospitals with proportionately more low cost cases. Again if the magnitude of the case mix indices of hospitals with large teaching programs are underestimated, then some of the effect on operating cost that was in fact due to case-mix would be attributed to the resident to bed ratio. Much of the source of error in the DRG prices should be eliminated if the prices are reestimated using more accurate diagnostic codes.

3. **Limitations in the DRGs:** The DRGs classify patients into one of 468 groups for payment purposes. Data used to group patients into DRGs are restricted to information that is readily available on the hospital discharge abstract.

Grouping variables include principal diagnosis, surgical procedures, complicating or comorbid conditions (based on secondary diagnoses), age and discharge status. Some of the DRGs are collections of more homogeneous patients than other DRGs. The coefficient of variation (a rough measure of homogeneity) of patient lengths of stay or charges within DRGs ranges from under .4 to over 1.6 with the coefficients of variation of the surgical DRGs being considerably smaller than those of the medical DRGs.[19] While part of the observed variation is attributable to coding errors and part due to varying levels of inappropriate care, some of it is due to the fact that some DRGs are aggregations of patients with very different resource needs. The less homogeneous the patients are within a given DRG, the more likely it is that hospitals will not get a random mix of patients within that DRG.

A number of people, including the Secretary in the *Report to Congress* and the Senate Finance Committee, argue that the teaching hospitals do not serve a random sample of patients within each DRG. They argue that teaching hospitals are likely to attract the sicker and more severely ill or the more difficult to diagnose patient. Research by Horn and by Knaus, et al provides support to these arguments.[20] However, research by Coffey and Goldfarb suggests that, based on disease staging, teaching hospitals do not treat a more severely ill patient population. To the extent that the DRGs fail to classify patients accurately and to the extent that the more costly patients within a DRG are treated by hospitals with large teaching programs, then some of the effect on operating costs that is due to patient mix will be attributed to the number of residents per bed.

4. **Factor Pricing:** The level of hospital costs is affected by the amount that hospital administrators pay for their "factors of production"—nurses, supplies, drugs, electricity and so forth. In the statistical analysis of the factors affecting Medicare costs per case, the only factor price that was taken into consideration was hospital wages—using a single wage index for an SMSA or for the rural areas of a state. However, there can be considerable variation in wages within an SMSA. The wages of workers who work in the central city are often higher than those in the suburban ring. For example, in a study of hospital costs in five metropolitan statistical areas it was found that wages were an average 17 percent higher in the county that formed the metropolitan core than they were in the suburban ring.[21] Thus, to the extent that hospitals with large teaching programs are more likely to be located in the central city, the estimated effect of residents per bed on Medicare operating costs will be slightly overestimated.

As noted above, labor is not the only factor of production which is used in the production of inpatient services. Food, energy, drugs, and so forth are also used. While some of these products are purchased in national markets, others are purchased locally. Regional price indices for factors of production other than labor are not currently available. However, cost

of living indices published for the major cities indicate that the price of food and electricity vary regionally, with higher prices often found in the Northeast.[23] Given that 39 percent of COTH member hospitals are located in the Northeast compared to 13 percent of nonmember hospitals, the omission of factor prices other than labor may lead to a slight upward bias in the estimated effect of residents per bed on costs, although this bias would be very small.

5. **Indirect Teaching Costs:** The indirect costs of teaching may be defined as those additional costs that are incurred by a hospital because it is engaged in graduate medical education and because it has a large number of residents directly involved in patient care. These costs do not include the easily identifiable direct costs such as the salaries paid to the teaching physician and the salaries of residents themselves.

The true indirect costs are inherently difficult to identify—which is the reason that statistical analysis is used to estimate them. However, one major source of these costs is the increased use of ancillary services in the provision of patient care. Almost all investigators have concluded that, controlling for the patient diagnosis, more ancillary services are provided in teaching hospitals.[24] One study, for example, found that the average charge for patients with congestive heart disease was 14 percent higher in teaching units than in private units with most of the difference attributed to the increased use of ancillary services.[25] A second study found that, within the study hospital, service charges were 60 percent higher on the teaching floors than on the nonteaching floors. (The researchers believed that the patients were comparable.)[26] Still a third study, which compared patient care patterns in a teaching hospital with those of a nonteaching hospital, found that charges were higher in the teaching hospital with most of the difference being attributable to the greater frequency of diagnostic testing.[27] The list could go on.

This increased use of ancillary services is primarily due to four factors: (1) the residents' relative inexperience and the fact that some of the extra testing represents learning by doing; (2) the tendency in teaching hospitals to try to make a more accurate diagnosis for both educational purposes and to satisfy the more academically minded physicians' "need to know" even in those circumstances where treatment will not be modified by the finding;[28] (3) the increased availability of state of the art testing facilities; and (4) the fact that very sick patients may be treated much more aggressively in these institutions.[29]

The increased use of ancillary services is thus highly correlated with the number of residents per bed. However, it must be pointed out that the increased use of ancillary costs will not be directly translated into a proportionate increase in ancillary costs since the marginal cost per test is generally low.

There are no doubt other costs that teaching hospitals incur because they have large teaching programs. These include factors such as more extensive and much more expensive medical record keeping, more complete medical libraries and so forth. In addition, because they have large teaching programs, these hospitals may feel that they are under more pressure to introduce state of the art technology with its higher costs.

These five factors are not the only ones that influenced the 1981 estimated statistical relationship between residents per bed and costs, but they are surely the most important ones. Thus it is likely that, if a better case mix classification system were available, if better cost weights were calculated and if more attention were paid to the different factor markets, the estimate of the association between Medicare costs per case and residents per bed would be less than "5.79" percent. How much less it is hard to say, but it would be surprising if it fell below 5 percent.

The Indirect Costs of Medical Education Considered Further

The term "indirect costs of medical education" has become increasingly murky over time. The discussion above should suggest that there are at least three ways in which this term is used. One is a *concept* which suggests that even after the direct costs of education are taken into account, the costs of providing patient care—to similar type patients—will be higher in hospitals with large graduate medical education programs. The second is an *estimate*. It is an estimate of the relationship between costs and residents per bed after controlling for other factors that are expected to influence hospital costs. The *estimated* relationship of the pure indirect effect of graduate medical education will depend on the other variables included in analysis; both the type of variables and how they are measured.

The third is a payment which is added to the standard DRG payment in order to both pay for the indirect costs of graduate medical education and to compensate for problems with the current DRG classification system. In practice this payment also compensates for some of the limitations in the current method of adjusting for factor price differences across geographic areas. The size of the payment is related to the estimated statistical relationship between costs and the resident to bed ratio. In fact, the estimated relationship is doubled.

Under the current prospective payment system, as noted above, the adjustment is tied to the size of the relationship between Medicare operating costs per case and residents per bed obtained from an analysis in which MSA size, hospital bed size, MSA wages or state rural wages and the Medicare case-mix index are used in the analysis. The payment adjustment is obtained by *doubling* the estimated size of the relationship. With the exception of these payments, the

level of the payment that a hospital receives for a given DRG will depend on its location (urban, rural) and area wages.

The design of the current prospective system and the payment adjustment for the indirect costs for medical education is inherently flawed. It is flawed first because it uses inadequate methods to adjust for differences in the economic environment in which hospitals provide care. In addition it is flawed because it ties the increased payments to teaching hospitals—payments designed to compensate them for unmeasured differences in their patient population—to the number of residents per bed and because the payment adjustment is *higher* than the estimated cost relationship between residents per bed and costs.

The design of the system leads to a somewhat inequitable allocation of Medicare payments among hospitals.

Suppose there is a large community with two 1200 bed hospitals. One hospital has 400 residents in training, while the other has 120. The first hospital will receive 20.8 percent more per DRG than the second although they are probably treating the same kinds of patients and pay the same amount for nurses, etc. On the other hand, two urban teaching hospitals located in the same MSA with the same size graduate medical program will receive the same payment per DRG although the one located in a suburban county probably faces lower labor costs than the one located in the central city.

These flaws, which have lead to a large payment to hospitals under the rubric "indirect costs of medical education," are likely to give rise to three quite different kinds of responses.[30]

First, given the intention of Medicare to limit the overall payments to hospitals, the relative financial advantage of institutions with large graduate medical education programs is likely to be perceived as unfair by other hospitals. Thus, these hospitals are likely to attack the double teaching adjustment in the same way that the Federation of American Hospitals attacked the federal Medicare waivers to the four rate setting states.[31] The reduction in Medicare payments to hospitals with large teaching programs would be offset by payments to those with none. Recently released data by HCFA is likely to encourage this response. HCFA reported in testimony to the Subcommittee on Health of the Senate Finance Committee that, "Our simulation indicates that approximately $204 per case would be withheld from all hospitals so that all teaching hospitals could receive an average of approximately $613 per case for indirect medical education."[32] These numbers, however, exaggerate the extent to which payments for indirect medical education affect the distribution of Medicare payments among hospitals for a given Medicare budget. If there were no payments for the indirect medical education adjustment, then the standardized DRG payments for all hospitals—including those hospitals with major graduate medical education programs—would increase and significantly larger DRG payments would flow to teaching hospitals, though the distribution of the payments among teaching hospitals might be different.

Second, separating the adjustment for the "indirect teaching costs" from the actual DRG rate and paying it as a lump sum makes the payment vulnerable as a source of federal budget savings. Thus it is only a matter of time before there is a pressure not only to reduce the size of the adjustment but also to coordinate the adjustment with federal manpower policies. For example, residents in specialties that are considered to be in excess supply could be eliminated from the count of residents used as the basis for the adjustment.

Third, other things being equal, residents are now a significant source of income. Given that residents salaries are included in the direct medical education pass through, hospitals may have strong incentives to try to increase their number of residents.[33] One way that a hospital can attract more residents is to increase their salaries, and thus it can be expected that there will be upward pressure on such salaries as the market begins to work. (This incentive, however, will be dampened if there is increased price competition among hospitals as a result of private sector initiative such as the promotion of HMOs or preferred provider organizations.)

A significant reduction in the size of the adjustment, however, will not eliminate those problems that generated the doubling in the first place.

The doubling arose because under the Secretary's original proposal, hospitals with large graduate medical education programs would have been disproportionately "penalized." From the perspective of time, it is clear that it is not understood that the reason for their being disproportionately penalized under that proposal was as much due to the failure of PPS to adjust for factor cost differences as it was to the inadequaceies of the case-mix classification system. One consequence of the doubling is that the "true indirect costs" of graduate medical education are exaggerated and that the political debate over the issue has become distorted.

Possible Evolution of the Prospective Payment System

In order to rectify some of the problems discussed above, it is ncecessary to make some changes in the design of the prospective payment system. These changes should make the system more equitable and help promote the efficient delivery of hospital services. It should be noted that many of the steps needed to implement these changes are already on the HCFA agenda.[34]

The first step is the most obvious one and one that HCFA can be expected to take. As soon as HCFA has at least 6 months of discharge data reported under PPS, it should recalibrate the DRG cost weights and

then recalculate each hospital's Medicare case-mix index. Since the reporting of diagnostic information was meaningful during that time period, the amount of error embedded in the data should decrease. Thus the DRG cost weights should improve and the estimated individual hospital's case-mix index be more accurate. Then HCFA should reestimate the teaching adjustment factor. One would expect that with more accurate case-mix data, the estimated value of the association between Medicare costs and the resident to bed ratio would decrease.

The second step is to modify the structure of the current DRGs. Some of the current DRGs are too heterogenous to be used in a payment system. In addition, the associated failure of the DRGs to adjust for severity will become more pernicious as the hospital specific component of the prospective payment system is phased out. Two short term possibilities should be explored. The first is to experiment with modifying the current DRG system based on information from other case mix classification systems based on discharge diagnosis such as staging[35] or patient management categories.[36] Second, the phase-in period would help to alleviate problems due to the classification system only if the actual case-mix of a given hospital were reasonably stable over time. In the long run, a new approach to classifying patients may be desirable. Research on reliable methods of severity measurement and on the development of classification systems that provide more clinically specific categories should be a top priority.

The third step is to improve the method used to estimate the DRG relative cost weights. Particular effort will have to be directed towards methods for allocating the routine and special care costs across the DRGs. (The other two factors that were identified above as causing problems with the current DRG cost weights—errors in patient discharge codes and cross price subsidization—should fall in importance over time as a result of both the Medicare PPS and increased competition among hospitals due to changes in private financing.)

The fourth step is to determine why hospital costs are so much higher in the larger Metropolitan Statistical Areas. As noted earlier, controlling for wages, residents per bed and the Medicare case-mix indices, HCFA analysts found that Medicare costs per case varied significantly with the size of the urban area. They found that hospital costs in urban areas of over a million population were 10.9 percent higher than hospitals located in rural areas; while hospitals located in urban areas with 250,000 to 1 million people, and those in urban areas with less than 250,000 population were 2.6 and .1 percent respectively more expensive. Subsequent research indicated that hospital costs in SMSAs with over 2.5 million people are significantly higher than those of hospitals located in areas from 1 to 2.5 million people.[37] Some of this cost differential may be due to unmeasured case mix differences. Most however, is likely to be due to the fact that the majority of hospitals in larger urban areas are located in the central city portion of the MSA and need to spend more on security and employee wages generally. Whatever the reason, if the size of the urban area is not taken into consideration, then *all* hospitals in those areas will be relatively adversely affected. One way to adjust for those differences, would be to treat each MSA as a separate group for rate setting purposes or to expand the number of locational factors used to set the national rates from two (urban/rural) to possibly 5 groups based on SMSA size. The first approach would be administratively complex while the second would exacerbate the boundary problem (hospitals in one MSA could receive significantly lower DRG payments than hospitals in a slightly larger MSA.) A different approach would be to slow down the phase in period.

A fifth step is to improve the information on factor prices. While HCFA is already engaged in a study to improve the wage data, it should also be encouraged to collect data on other factors of production that are purchased in local areas. In addition, the relevant geographic area used to adjust for factor price differences should be reconsidered. Currently, the MSA is the relevant geographic area for determining wage differences. However, as noted above, wages in the core county are often higher than wages in the counties making up the suburban ring. If this wage differential is not taken into consideration, then hospitals located in the core county will be adversely impacted. The problem of defining the relevant market area for assessing factor price differences is especially serious. The current urban subdivisions are defined as aggregates of counties which are historical political artifacts. (Similar problems exist among and within the rural counties of states.) However the setting of different wage indices for different areas within an MSA would again create a major boundary problem. Two hospitals across the street from each other, one in the suburban ring and the other on the perimeter of the core county, could receive quite different payments for a given DRG.

Thus, there are many modifications that will have to be made in the design of the prospective payment system. The first three steps relate to changes that will have to be made in the patient classification system and the mechanism for setting relative payments. The fourth and fifth steps relate to methods for adjusting for geographic variations in factor costs that depend on location. For Medicare, a national system, at least as much attention must be given to the last two steps as to the first three. One way of underlining the importance of the last two steps is that even if it were possible to develop a perfect classification system and an accurate set of relative prices for the DRGs, hospitals in the large MSA's and in the core counties within the MSAs (many of which are teaching hospitals) would be relatively adversely impacted under a national prospective payment system as currently designed.

Hospitals with large medical education programs would be relatively adversely impacted even if they received a payment adjustment for the "true" indirect costs of medical education.

A satisfactory completion of these steps may be impossible and Medicare may seek methods of delegating the payment decisions. Two separate approaches are feasible. First, the federal government could encourage the establishment of state rate setting programs. In this case the methods for paying hospital care would be determined by the states. Second, Medicare could establish capitated systems for Medicare beneficiaries—in which case the organization responsible for providing services would also be responsible for negotiating with hospitals the amounts to be paid for hospital care. Neither of these approaches solves the problems of how to pay hospitals, but they do decentralize the decision to entities that are more able to take local market conditions into consideration.

In addition to the five steps just discussed, HCFA should undertake a study which compares the variation in hospital costs per admission with the total cost of an illness episode. It is possible that the higher costs incurred by the ancillary-intensive teaching hospital admission are offset, at least partially, by the use of fewer medical services during the illness (e.g., fewer re-admission or fewer ambulatory care services) or by fewer days of restricted activity for the patient. No study has examined the costs of teaching and non-teaching hospitals in light of the patient's total illness costs; such a study is needed and should be on HCFA's research agenda.

VI. Summary and Conclusions

The adjustment for the higher costs of teaching used in establishing the routine 223 limits was a reasonable step to take in 1980. The label attached to this adjustment, however, was misleading. The adjustment took into account not only the higher costs associated with medical education but also unmeasured cost factors that were correlated with the number of residents per bed. The continuation of an adjustment for indirect costs under prospective payment was also a reasonable step to take in 1983. However the magnitude of the adjustment made in 1983 was less justifiable and of considerably more importance to the hospital industry than the one made in 1980. It was less justifiable because it resulted from a pragmatic decision to double an estimated number, and it was of considerably more importance because the amount of dollars at issue was considerably higher.

The current adjustments are somewhat larger than would be considered equitable when the payment rates for all hospitals are considered together, and they lead to an inequitable distribution of Medicare payments across hospitals, not only between teaching and nonteaching hospitals but also across teaching institutions. However, it must be remembered that the size of the current adjustment is partly a consequence of an initial decision to take only a limited number of geographic factors into consideration in setting the payment rates.

The magnitude of the payments made under the rubric of the indirect costs of medical education is likely to make the adjustment a subject of attack by other hospitals. In addition, these payments are likely to be considered as a potential source of budget savings by the Administration and Congress. Nevertheless unless differences in the types of patients treated and the differences in factor prices in the markets where teaching hospitals are concentrated are taken into consideration, any significant lowering of the resident to bed adjustment may put a disproportionate number of teaching hospitals at significant financial risk. Innovative methods for accounting for these factors must be developed if the prospective payment system is to be sustained. This paper has made some suggestions on how to proceed.

The current experiment in hospital pricing under Medicare and the increase in competition in the private sector represent a radical change in the financing of hospital services. This is an experiment that only America has dared to try. No other country has attempted to develop fee schedules for in-patient hospital care. We are sailing an uncharted sea, and must sail carefully.

FOOTNOTES

1. Federal Register. *Medicare Program; Proposed Schedule of Limits on Hospital Inpatient General Routine Costs for Reporting Periods Beginning on or after July 1, 1980.* Vol. 45, No. 4.
2. This number was derived from information included in a statement by Henry R. Desmaris, Director, Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administrator before the Subcommittee on Health, Finance Committee, U.S. Senate October 1 1984.
3. There was an effort to determine whether the higher routine per diem costs in teaching hospitals were associated with a more costly case-mix. This effort was not fruitful because an appropriate case-mix index was not available.
4. Federal Register. *op. cit.* p. 21584.
5. Alternatives considered and rejected included paying teaching hospitals the same DRG rate as nonteaching hospitals, making the indirect Graduate Medical Education (GME) adjustment a function of the direct GME pass through payment and setting a flat rate per resident per bed.
6. Secretary of Department of Health and Human Services. *Hospital Prospective Payment for Medicare: A Report to Congress.* Washington, D.C., December 1982, pp. 47-48.
7. *Ibid.* pp. 48-49.
8. The actual estimating equation is:

$$\begin{aligned} \text{lnCPC} = {} & 7.32 + 1.011\ \text{lnCMI} + 1.022\ \underset{(29.63)}{\text{lnWage}} \\ & + \underset{(12.72)}{.579\ \text{lnR}} + \underset{(24.43)}{.119\ \text{lnBeds}} + \underset{(.58)}{.0007\ \text{SCV}} \\ & + \underset{(5.29)}{.026\ \text{MCV}} + \underset{(60.67)}{.109\ \text{LCV}} \qquad R = .75 \end{aligned}$$

Where:

CPC is the Medicare operating cost per case; CMI is the Medicare case-mix index; wage is the wage index; R is Residents per bed; beds is hospital bed size; SCV is urban area with a population of less than 250,000; MCV is urban area with a population of 250,000 to 1,000,000, and LCV is urban area with over 1,000,000 population and ln represents natural logarithm.

9. Senate Finance Committee Report. *Social Security Amendments of 1983.* Report No. 98-23. Washington, D.C. March 11, 1983 p. 52.
10. Department of Health and Human Services, Health Care Financing Administration. "Medicare Program: Prospective Payments for Medicare Inpatient Hospital Services, Interim Final Rule with Comment Period." *Federal Register,* Thursday, September 1, 1983, p. 39778.
11. These results are given in footnote 8 above.
12. The reason for this is quite technical. Statistically, if there is a variable that is excluded from the model that affects hospital costs, and which is also directly related to one of the variables in the model, the coefficient of the included variable will be biased upwards to include the effect of the omitted variables.
13. The Institute of Medicine estimated that approximately 20 percent of the records in the file used by HCFA to construct the case-mix index had an erroneous principal diagnosis at the DRG level. Institute of Medicine. *Reliability of Medicare Hospital Discharge Records.* National Academy of Sciences. NTIS. PB 281680, November 1977.
14. J. Pettengill and J. Vertrees. "Reliability and Validity in Hospital Case-Mix Measurement." *Health Care Financing Review* 4 (2), 1982: 101-127.
15. Personal Communication, James Bentley, Department of Teaching Hospitals, AAMC.
16. Judith R. Lave. "Note on the Compression in the HCFA DRG Prices." Unpublished paper, University of Pittsburgh, 1984.
17. Work by Fitzmaurice indicated that routine per diem nursing salaries, a major component of routine costs per day, are significantly related to the Medicare case-mix index. See M. Fitzmaurice. "A Statistical Analysis of the Medicare Routine Nursing Differential." *Health Care Financing Review.* 5 (1) 1983: 45-64. Additional evidence on this issue is presented in J. Thompson. "The Measurement of Nursing Intensity." *Health Care Financing Review.* In press.
18. Office of Technology Assessment. *Diagnosis Related Groups and the Medicare Program.* Implications for Medical Technology. Washington 1983.
19. Unpublished data. Bureau of Data Management and Strategy. HCFA.
20. S. Horn. "Measuring Severity of Illness: Comparisons Across Institutions." *American Journal of Public Health.* 73(1), 1983:26-31. E.A. Draper, D.P. Wagner, and W.A. Knaus. "The Use of Intensive Care: A Comparison of a University and a Community Hospital." *Health Care Financing Review.* 3(2), 1981:40-64.
21. R. Coffey and M. Goldfarb. "DRGs and Disease Staging for Reimbursing Medicare Patients." Working Paper. National Center for Health Services Research, 1984.
22. J.L. Ashby. *The Inequity of Medicare Prospective Payments in Large Urban Areas.* District of Columbia Hospital Association. September 1984.

23. J.R. Lave. "Hospital Reimbursement Under Medicare." *Milbank Memorial Fund Quarterly*. 62(2), 1984:251-268.

24. The one exception is a paper by Becker and Sloan which reported no difference in the use of ancillary services between teaching and nonteaching hospitals. See. E. Becker and F. Sloan. "Utilization of Hospital Services: The Roles of Teaching, Case-Mix and Reimbursement." *Inquiry*. 20(3), 1983:248-264.

25. M.L. Garg et al. "Reimbursing for Residency Training, How Many Times." *Medical Care*. XX(7), 1982:719-726.

26. E.W. Martz and R. Ptakowski. "Educational Costs to Hospitalized Patients." *Journal of Medical Education*. 53(May) 1978:383-38.

27. S.A. Schroeder and D.S. O'Leary. "Differences in Laboratory Use and Length of Stay Between University and Community Hospitals." *Journal of Medical Education*. 52(5), 1977:418-420.

28. D.B. Reuben. "Learning Diagnostic Restraint." *New England Journal of Medicine*. 310(9), 1984: 591-593.

29. A. Garber, V. Fuchs and J. Silverman. "Case Mix, Costs and Outcomes." *NEJM*. 310(19), 1984.

30. Some of these same issues are described in M.E. Whitcomb. "The Federal Government and Graduate Medical Education." *The New England Journal of Medicine*. 310(20), 1984:1322-1324.

31. Federation of American Hospitals "Potential Inequities of Medicare Waivers" Statement. No date. Washington, D.C.

32. Henry R. Desmaris. *op cit* p. 8.

33. J. Newhouse "Two Prospective Difficulties With Prospective Payment for Hospitals, or It's Better to Be a Resident Than a Patient With a Complex Problem." *Journal of Health Economics*. 2(3), 1983:269-274.

34. S. Jencks et al. "Evaluating and Improving the Measurement of Hospital Case-Mix." *Health Care Financial Review*. Annual Supplement. 1984 in press.

35. J.S. Gonnella, M.C. Hornbrook and D.Z. Louis. "Staging of Disease: A Case Mix Measurement." *JAMA*. 1984.

36. W. Young et al. "Hospital Case Mix: Development and Implementation." Health Care Research Department, Blue Cross of Western Pennsylvania. Pittsburgh 1983.

37. G. Anderson and J. Lave. "The Costs of Teaching Hospitals." Work in Progress.

Senator QUAYLE. Our final witness is Dr. Robert S. Stone, on behalf of the American Medical Association. He is dean of the College of Medicine at Texas A&M University.

Dr. Stone?

Dr. STONE. Thank you, Senator Quayle, Senator Simon.

With me are M. Roy Schwarz, vice president for medical education and scientific policy of the AMA, and Harry N. Peterson, director of AMA's division of legislative activities.

We are pleased to have an opportunity to talk with you. We have presented a written——

Senator SIMON. Excuse me. If I may just comment, the two who are with you are from the State of Illinois, and we are pleased to have them here.

Senator QUAYLE. Oh, yes, of course.

Dr. STONE. We have submitted a written statement, of course, and I have a briefer version of that, which I will present orally.

And, as the last formal speaker, I might say this has been a delightful seminar. It really has been great, and very instructive and enjoyable. It has been good to be here.

Mr. Chairman, until an appropriate alternative is developed, the AMA strongly supports the current system of financing the majority of graduate medical education costs through patient care revenues from third-party payers, including Medicare.

A key benefit of the existing system is the stable patient care environment it has fostered. We are concerned over proposals to restructure or dramatically reduce the funding of graduate medical education, because no stable alternative funding sources have been identified. Without adequate and predictable financial support, teaching hospitals would be forced to choose between two undesirable alternatives—eliminate essential teaching programs that are an integral part of the system, that provide care to the sick, or face

large revenue shortfalls. The latter, I think, is an impossible situation.

The AMA opposes the reductions in graduate medical education funding proposed in President Reagan's fiscal year 1986 budget. We are particularly concerned over the proposed 50 percent cut in indirect medical education payments. Many inner city hospitals that provide substantial amounts of uncompensated or insufficiently compensated patient care would be severely affected by such a reduction.

We also believe that it is premature to alter hospital reimbursement until sufficient data is available concerning the impact on hospitals of the recently implemented prospective payment system, especially in light of a major flaw in the DRG system, its failure to reflect severity of illness and intensity of care.

The AMA believes strongly that an in-depth study of the financing of graduate medical education should be undertaken before Congress makes any cuts in funding. I think that in that sense, this hearing is tremendously reassuring, to see the care that is being put into examining these issues. To this end, the AMA has established an ad hoc committee which will conduct a thorough study of the financing of graduate medical education.

Mr. Chairman, we have reviewed the principles enumerated by you, Senator Quayle, in the January 31, 1985, Congressional Record. The AMA agrees with the principle that every graduate of a medical school accredited by the LCME should have the opportunity to compete successfully for a position in an approved graduate medical education program. Alternatively, I do not know what those young men and women would do—that is, they must have that training. We do not want them entering practice, I think, without that.

The AMA also agrees that medical school graduates cannot be guaranteed a residency position in the specialty of their choice. In fact, medical school graduates have never, had such an assurance. Nevertheless, we believe that in general it is beneficial to our health care system for qualified graduates to be able to the greatest extent possible to train in the area of their choice.

Finally, the AMA supports the principle that an institution's graduate medical education program must meet uniform standards of quality developed by private sector bodies in order for the institution to be eligible for Medicare funding for its teaching program. Such standards currently exist, and Medicare reimbursement is now so conditioned. The Accreditation Committee on Graduate Medical Education is a recognized private sector accrediting body for all domestic graduate medical education programs.

We also have the following comments concerning the proposals outlined by Senator Quayle.

At the outset, Mr. Chairman, we want to state our strong concern over the use of the Medicare Program to fashion manpower policies which affect the entire health care delivery system. The AMA is also concerned about conditioning Medicare funding to a requirement that some majority of residency positions offered by a hospital or a group of hospitals at any one time must be in the primary care specialty. Such a requirement would be too rigid for a hospital or group of hospitals to achieve.

For example, some teaching hospitals might find it extremely difficult to establish or expand pediatrics or Ob-Gyn residencies, because of insufficient numbers of patients to run a high-quality program and meet standards of accreditation as established by the ACGME.

Other factors which could hamper a teaching hospital's ability to increase its proportion of residency positions in the primary care specialties include a lack of necessary faculty or facilities. The AMA believes that it is extremely difficult to determine the number and type of physicians needed throughout the country. Because of the inherent difficulty in predicting future physician needs, and because of our belief that market forces should in the main determine the number and specialty positions, the AMA has opposed the establishment of a governmental body with the authority to determine the number of residency positions and their allocations.

We recognize, however, the necessity for monitoring and reporting periodically on trends in health manpower. And, Mr. Chairman, the AMA has performed this function for many years.

I was delighted with Dr. Thompson's comments on this issue of what physicians actually do. That whole matter must be gone into, I think, in much greater depth. I had not heard it previously mentioned, and he alluded, I think, to some pathfinding studies in that regard.

We are greatly concerned that the proposal to pay the graduate medical education costs of a teaching hospital only if at least 75 percent of the residents in the program are graduates of an LCME-approved U.S. medical school could cause substantial disruption in the provision of patient care in many inner city hospitals. You have heard considerable testimony on that.

Currently, there are 274 teaching hospitals wherein fewer than 75 percent of their residents are graduates of an LCME-approved medical school. Many of the hospitals are in the inner cities and serve large numbers of low-income and indigent patients.

Parenthetically, I think there has been some allusion to another dimension of that. I wish I had the figures, but in PM&R, physical medicine and rehabilitation, a very substantial proportion of the residents in the program are foreign medical graduates. For some reason, it has proved attractive to them. And I think we are going to have to look at that dimension, too, if we were to restrict funding. I wish I had the figure; it would make it more useful to you.

Senator QUAYLE. Perhaps you could submit that to us for the record.

Dr. STONE. Yes, sir. We will endeavor to get it, if it is available, indeed.

Finally, the essentials of an accredited residency program upon which the ACGME bases its accreditation do not require that a program have an affiliation agreement with a U.S. medical school in order to be accredited. The AMA, a sponsoring member of the ACGME, has always been in accord with these essentials. While the vast majority of U.S. teaching hospitals currently have affiliation agreement with a medical school, the fact that a teaching institution lacks an affiliation agreement should not be construed as an indication that the teaching program is of poor quality.

Moreover, it must be kept in mind that Medicare currently recognizes only those programs that have received ACGME accreditation. In our view, affiliation should not be required for Medicare recognition.

In conclusion, Mr. Chairman, we are extremely concerned over the proposal to significantly change the existing system of financing graduate medical education before satisfactory alternative sources of funding are identified. The system of financing graduate medical education is complex, and changes must be carefully considered. Precipitous action could undermine not only our graduate medical education system, but the quality of our health care system as a whole.

As I have indicated, the AMA is in the process of a detailed study of this subject. We will be pleased to keep the committee advised of developments and to work with the committee as it proceeds to consider this issue.

Mr. Chairman, I will be happy to answer any questions members of the committee may have.

I particularly would like a chance to comment on this issue of clinical competence, the clinical competence examination.

Senator QUAYLE. Go ahead.

Dr. STONE. Thank you.

You know, some of us—and you might be among them—have had in our undergraduate education—that is, in college, in our baccalaureate graduation and high school—we study foreign languages, we might have Latin, we have mathematics, and we have economics, and we have citizenship and American history. And, at some point, we can pass an examination, a content exam. But the discipline, the exposure to those educational experiences continue for an entire lifetime to influence what we say and what we do. And I think there is a very important similarity in this issue of the clinical competence examination.

The rigor of the medical education initiation, if one wants to call it that, or experience, the discipline of the basic sciences, what they do to a person's thinking, his manner of thinking, the rigor of his thinking, the background information that he has about his subject, the whole way that he approaches problems, I do not think can be adequately addressed in a one-time examination, a one-time biopsy or look at the individual's knowledge base.

And I think we have no way of measuring what that profound influence has been, and there is no way, in my view—and it is a subject matter, it is an opinion—to make up for that deficit merely through good residency training programs. They do a good job, but they never make up for that background, that indoctrination—and "indoctrination" is a hazardous word for me to use, perhaps. I do not mean a social indoctrination, I mean an intellectual indoctrination.

Thank you, sir.

[The prepared statement of Dr. Stone and responses to questions of Senator Kennedy follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Employment and Productivity
Committee on Labor and Human Resources
United States Senate

Presented by

Robert S. Stone, M.D.

Re: Funding of Graduate Medical Education

March 25, 1985

Mr. Chairman and Members of the Committee:

My name is Robert S. Stone, M.D., and I am Dean of the College of Medicine of Texas A&M University. I am also the Delegate of the Section on Medical Schools to the American Medical Association's House of Delegates. Accompanying me are M. Roy Schwarz, M.D., Vice President for Medical Education and Science Policy of the AMA, and Harry N. Peterson, Director of AMA's Division of Legislative Activities. The AMA is pleased to have the opportunity to testify before this Committee concerning graduate medical education and its financing.

The AMA has a long history of direct involvement in and support for quality medical education. High quality medical care for the American public is dependent upon the existence of a large cadre of well trained physicians and other health care professionals.

The education of physicians is a long and arduous process requiring years of classroom work with increasing exposure of students and physicians-in-training to the practical aspects of patient care. The first two years of education in medical school focus generally on the basic medical sciences in classroom and laboratory experiences. In the last two years, as students study clinical sciences, there is increasing integration of the student into the patient-care team at the bedside. After graduation from medical school, intensive participation in patient care begins in the form of graduate medical education. Graduate medical education, commonly referred to as residency training, places the physician-in-training in a learning and service environment in which he or she cares for patients under the supervision of licensed physicians/teachers. The resident participates in the diagnosis and management of large numbers of patients who present a wide spectrum of disease conditions. The training program is designed to offer the resident increasing levels of responsibility and to prepare him or her for the independent practice of medicine. In this way the resident acquires the requisite knowledge and skills of his or her chosen specialty.

It is through the provision of patient care in a teaching environment that a physician learns the practice of clinical medicine. It is difficult if not impossible to separate the learning and service components of graduate medical education. In your statement in the Congressional Record, Mr. Chairman, you have stated this tenet well, namely, that education and patient care are interwoven in graduate medical education programs.

The U.S. medical education system, both undergraduate and graduate, is second to none and is an essential component for assuring high quality health care for the American people. We believe strongly that in order to maintain this position, a stable environment must exist for the financing of graduate medical education.

Mr. Chairman, the existing system of financing graduate medical education and training is complex. Changes must be carefully evaluated and considered since an ill-advised change could threaten the nation's ability to train qualified physicians in sufficient numbers to meet the health needs of our nation in the future.

Benefits of the Existing Financing System

Until an appropriate alternative is developed, the AMA strongly supports the current system for financing the majority of graduate medical education costs through patient care revenues from third party payors including Medicare. A key benefit of the existing system is the stable financial environment it has fostered. This predictable financial environment, in which teaching hospitals are assured that payment will be made for reasonable direct and indirect medical education costs, has been a major reason for the number of high quality teaching programs available. We are concerned over proposals to restructure or dramatically reduce the funding of graduate medical education because no stable alternative funding sources have been identified. Without adequate and predictable financial support, teaching hospitals would be forced to choose between two undesirable alternatives: eliminate essential teaching programs that are an integral part of the system that provides care to the sick or face large revenue shortfalls.

Teaching hospitals and their residency programs provide a number of significant benefits to the general public. Certainly, all of society benefits from having an adequate supply of highly trained physicians in all medical specialties. In addition, teaching hospitals generally have more special care units such as units to treat burns or heart attack than do non-teaching hospitals. As a result, teaching hospitals often serve as the medical referral center for an area offering tertiary care unavailable elsewhere in a community. Finally, residents under the supervision of attending physicians provide quality patient care. In the absence of residents, hospitals would be forced to utilize more practicing physicians thereby increasing the cost of physician services.

The present system recognizes that legitimate reasons exist for higher patient costs at teaching hospitals. Teaching hospitals generally treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients. In addition, because teaching hospitals usually contain many special care units, overall occupancy rates may be lower than those of non-teaching hospitals where beds may be available for general admission. Finally, residents place significant demands on the resources of teaching hospitals that are not found in community hospitals without teaching programs.

Administration's Budget Proposals

President Reagan's fiscal year 1986 budget proposes to reduce Medicare reimbursement for teaching hospitals' direct medical education costs to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The President's budget also would cut indirect medical education payments by 50%.

The AMA opposes the reductions in graduate medical education funding proposed in the President's budget. We are particularly concerned over the proposed 50% cut in indirect medical education costs. The impact of such a reduction would vary considerably from hospital to hospital. Many inner-city teaching hospitals that provide substantial amounts of uncompensated or insufficiently compensated care would be severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact on hospitals of the recently implemented prospective payment system. This is particularly true in light of a fundamental flaw in the DRG system -- the failure to reflect severity of illness and case-mix differentials.

Thus, the AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress makes any cuts in funding. To this end, the AMA has established an Ad Hoc Committee which will conduct a thorough study of the financing of graduate medical education.

Medical Education Principles

Proposed by Senator Quayle

In the January 31, 1985, Congressional Record, Senator Quayle enumerated three principles which he stated should be considered in any legislative proposal to link Medicare support for graduate medical education programs with "institutional compliance with national guidelines reflecting sensitivity to physician manpower issues." In effect, Medicare would assume responsibility concerning the number and

specialty distribution of physicians. At the outset, Mr. Chairman, we want to state our strong concern over the use of the Medicare program to fashion manpower policies which affect the entire health care delivery system.

We have reviewed the three principles enunciated by Senator Quayle. The AMA agrees with the principle that every graduate of a medical school accredited by the Liaison Committee on Medical Education (LCME) should have the opportunity to compete successfully for a position in an approved graduate medical education program.

The AMA also agrees that medical school graduates cannot be guaranteed a residency position in the specialty of their choice. In fact, medical school graduates have never had such an assurance. Nonetheless, we believe that, in general, it is beneficial to our health care system for qualified graduates to be able to the greatest extent possible to train in their area of choice.

Finally, the AMA supports the principle that an institution's graduate medical education program must meet uniform standards of quality developed by private-sector bodies in order for the institution to be eligible for Medicare funding for its teaching program. Such standards currently exist and Medicare reimbursement is now so conditioned. The Accreditation Committee on Graduate Medical Education (ACGME) is the recognized private-sector accrediting body for all domestic graduate medical education programs. It is the ACGME and its predecessors that have developed the standards of approved residency programs. Those standards, along with ongoing monitoring of programs to assure

compliance, have provided for a graduate medical education system in this country that is the standard by which others are measured. We urge you to support a continuation of the ACGME's efforts in this area which have been fulfilling the criteria specified.

Senator Quayle's Proposals

Senator Quayle has also set forth a number of proposals for implementing the aforementioned principles. These proposals and our comments concerning each are set forth below:

1. In order to be eligible for Medicare funds, some majority of positions (possibly 70%) offered by a hospital or group of hospitals sharing an affiliation agreement with a U.S. medical school must be in the primary care specialities of internal medicine, family medicine, pediatrics and obstetrics/gynecology.

The AMA is very concerned about conditioning Medicare funding to a requirement that the majority of residency positions offered by a hospital or group of hospitals at any one time must be in the primary care specialties. Such a requirement could be too rigid for a hospital or group of hospitals to achieve. For example, some teaching hospitals may find it extremely difficult to establish or expand pediatrics or obstetrics/ gynecology residencies because of an insufficient number of patients to run a high quality program and meet standards of accreditation as established by the ACGME. Other factors which could hamper a teaching hospital's ability to increase its proportion of residency positions in the primary care specialties include a lack of necessary faculty or physical facilities. Because of the serious effects on teaching institutions, any requirement for substantial increases in primary care positions would need an extended period of time for implementation.

2. A private sector entity would be responsible for monitoring physician manpower data and making periodic recommendations on the percentage of positions to be allocated to primary care training.

Mr. Chairman, we must caution that it is extremely difficult to determine the number and tvpes of physicians that are needed throughout the country. References are often made to the reports of the Graduate Medical Education National Advisory Commission (GMENAC) and its predictions for future physician needs by specialty. While the GMENAC report is widely quoted, the methodology used is not universally accepted as valid, and it is generally recognized that inaccuracies exist in the report.

Because of the inherent difficulty in determining future physician needs and because of our belief that market forces should in the main determine the number and specialty mix of residency positions, the AMA has opposed the establishment of a governmental body with the authority to determine the number of residency positions and their allocations. We recognize, however, the necessity for monitoring and reporting periodically on trends in health manpower, and, Mr. Chairman, the AMA has performed this function for many years.

3. Medicare would pay the graduate medical education costs of a teaching hospital only if at least 75% of the residents in the program are graduates of an LCME-approved U.S. medical school.

Currently, there are 274 hospitals (with one or more accredited residency programs) wherein fewer than 75% of all residents are graduates of an LCME-accredited medical school. Many of these hospitals are in metropolitan areas and a number serve large numbers of low-income and indigent patients. We are greatly concerned that this proposal could

cause substantial disruption in the provision of patient care in such hospitals. We believe that some special provision would need to be made, possibly in the form of a waiver, for inner-city teaching institutions.

4. In order to be eligible for Medicare funds for its teaching program, an institution must have an affiliation agreement with a U.S. medical school.

The essentials or an accredited residency program, upon which the ACGME bases its accreditation, do not require that a program have an affiliation agreement with a U.S. medical school in order to be accredited. The AMA, a sponsoring member of the ACGME, has always been in accord with these essentials. While the vast majority of U.S. teaching hospitals currently have an affiliation agreement with a medical school, 135 hospitals with one or more accredited residency programs currently do not have an institutional medical school affiliation. Affiliation agreements should provide mutual benefits for hospitals and medical schools. Such affiliation agreements should continue to be voluntary and we must stress the resource and administrative involvement by both parties for fulfillment of these agreements. The fact that a teaching institution lacks an affiliation agreement, however, should not be construed as an indication that the teaching program is of poor quality. Moreover, it must be kept in mind that Medicare currently recognizes only those programs that have received ACGME accreditation. In our view affiliation should not be required for Medicare recognition.

Conclusion

The U.S. medical education system, both graduate and undergraduate, is the benchmark against which other medical education systems in the world are judged. Preeminence in graduate medical education has been

achieved by virtue of our commitment to high quality medical care, the dedication of medical schools and teaching hospitals to high-caliber education, and the existence of stable funding mechanisms.

We are extremely concerned over proposals that would significantly change the existing system of financing graduate medical education before satisfactory alternative sources of funding are identified. The system of financing graduate medical education is complex and changes must be carefully considered. In fact, the impact of recent changes in the funding of medical care on residency programs cannot be completely determined at this time. Precipitous action could undermine not only our graduate medical education system but the quality of our health care system as a whole.

We are also concerned about the concept that government controlled central planning of career choice in the medial profession is the preferred or appropriate method of correcting perceived manpower imbalances. We urge Congress to continue its long-standing commitment to quality graduate medical education and ensure that the Medicare program continues to pay its fair share of the costs of a system that benefits Medicare beneficiaries and the nation as a whole.

As I have indicated, the AMA is the process of a detailed study of this subject. We will be pleased to keep the Committee advised of developments and to work with the Committee as it proceeds to review this subject.

Mr. Chairman, thank you for providing us with this opportunity to testify. I will be happy to answer any questions Members of the Committee may have.

APPENDIX
HISTORY OF FINANCING
GRADUATE MEDICAL EDUCATION

DIRECT FEDERAL ASSISTANCE

The federal government has provided direct assistance to the support of selected residency programs. This direct assistance, through grants under Title VII of the Public Health Service Act, support residency training in the areas of family medicine, general internal medicine and general pediatrics. These programs were initiated by the Congress to place an increased emphasis on training in these specialties.

MEDICARE

Graduate medical education is also financed out of payments for hospital services. In this regard, Medicare, through its coverage of hospital services, provides financial support for residency programs.

Payment for GME Under Cost-Based Reimbursement

From the inception of the Medicare program, teaching hospitals have been reimbursed on a "reasonable cost" basis for their direct medical education costs. Direct medical education costs are expenses directly related to a hospital's teaching activity. These costs include the salaries and fringe benefits of residents and the portion of teaching physicians' salaries that is attributable to educational activities.

For many years, teaching hospitals received no special payment for expenses indirectly related to the teaching of residents. Instead, provisions for reimbursement of ancillary services and the "cost-based" reimbursement system covered these costs. Then in order to prevent a disproportionate number of teaching hospitals from being adversely affected by the existing Medicare limits on reimbursement of routine hospital operating costs, HHS in 1980 modified the limits to include a resident-to-bed adjustment for the indirect costs of graduate medical education. These costs reflect the increased demands that residents place on other hospital staff and the tendency of residents to provide more services and conduct more tests. Indirect medical education costs are also used to reflect case-mix intensity. The indirect medical education adjustment was set initially at 4.7% for each 0.1 full-time equivalent (FTE) resident per bed. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) replaced the routine cost limits with limits that covered total inpatient operating costs thereby including special care unit costs under the limits. As a result, for hospital cost reporting periods beginning on October 1, 1982, the resident-to-bed adjustment was increased from 4.7% to 6.06% for each 0.1 FTE resident per bed.

Payment Under The Prospective Payment System

The Prospective Payment System (PPS), established under Title VI of the Social Security Amendments of 1983 (P.L. 98-21), retained special treatment of direct and indirect medical education costs.

Direct Medical Education Costs Under PPS

In its 1982 report to Congress entitled Hospital Prospective Payment for Medicare, HHS advocated a continuation of cost-based reimbursement for direct medical education costs. The report stated:

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care.[1]

Congress agreed that the direct costs of medical education should not be included in the diagnosis-related group (DRG) payment. Thus under PPS, teaching hospitals are reimbursed for their direct medical education expenses on a reasonable-cost basis in addition to the DRG-based per case payment. Medicare's portion of a hospital's direct medical education costs is calculated based on generally accepted accounting principles and includes, in addition to salaries and fringe benefits, allocated overhead expenses such as administration, maintenance, and utilities.

Indirect Medical Education Costs Under PPS

The HHS report also proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. The report stated:

> The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education

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[1] U.S. Department of Health and Human Services. Hospital Prospective Payment for Medicare December 1982 PP. 47-48

> results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.
>
> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.[2]

Congress also concurred with this recommendation and, because of analyses showing that teaching hospitals would suffer greater financial losses than non-teaching hospitals under the DRG system, P.L. 98-21 doubled the existing educational adjustment factor. In reporting the legislation, the Senate Finance Committee acknowledged that an additional payment to teaching hospitals for indirect medical education expenses is appropriate

> . . . in the light of serious doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.
>
> The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process. The committee emphasizes its view that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post graduate medical education of physicians which the Medicare program has historically recognized as worthy of support under the reimbursement system. (Emphasis added)

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[2] Id. at 48-49

Under PPS the indirect medical education adjustment provides an 11.59% increase in the DRG portion of the prospective payment rate for each 0.1 FTE resident per bed. Medicare regulations define the number of a hospital's FTE residents to be the sum of the number of residents employed at least 35 hours per week, plus one-half of the number of residents who work less than 35 hours per week. The recently enacted Deficit Reduction Act (P.L. 98-369) included an amendment that permits teaching hospitals to count all residents who provide services in the hospital, regardless of whether they are employees of the hospital.

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AMA Response To Question From Senator Kennedy

Question

Do you feel that any action should be taken within the medical education community to relieve the projected undersupply of physicians in specific specialty areas, since the market has not yet been effective in serving this need? (i.e., child and adult psychiatry, rehabilitation medicine, therapeutic radiology, etc.)

Answer

The AMA believes that shortages of physicians do exist at the present time in certain specialty areas including child and adult psychiatry, rehabilitation medicine and therapeutic radiology. However, because of increased competition for residency positions, more medical school graduates are choosing previously unpopular specialties. According to the Directory of Residency Training Programs published by the AMA, the number of residents in physical medicine and rehabilitation has increased from 492 in 1980 to 727 in 1984. Similarly, the number of residents in therapeutic radiology has grown from 288 in 1982 to 522 in 1984. Finally, the number of residents in child psychiatry has risen from 426 in 1980 to 537 in 1984.

The AMA believes that, in general, market forces should determine the number and specialty mix of residency positions. Because evidence indicates that competitive pressures may begin to alleviate some of the shortages, we believe the government should adopt a cautious approach concerning federal assistance for specific specialty areas. Only where it is clear that market forces are inadequate would we support a carefully targeted program of federal grants to encourage medical school graduates to enter specialty areas that are experiencing an undersupply of physicians.

Additional Material For Record

At the hearing Dr. Stone stated (p. 123 - ln. 21) that the AMA would provide the Committee with statistics concerning the proportion of residents in physical medicine and rehabilitation that are graduates of foreign medical schools.

According to the Directory of Residency Training Programs, in 1983, 40.2% of residents in physical medicine rehabilitation were foreign medical graduates (FMGs). However, in 1984, only 33.6% were FMGs.

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Senator QUAYLE. I understand, Dr. Thompson, you have a plane to catch. I do not have any questions for him, if he wants to be excused, but I do have some questions for Dr. Stone and Dr. Buchanan.

Senator Simon, do you have questions of Dr. Thompson?

Senator SIMON. If I can just ask Dr. Thompson one question that is really not pertinent to our discussion here. But you state, "Total hospital expenses for the past year have increased by only 4.5 percent, while in-patient expenses increased by only 3.2 percent."

First of all, the figures are great, and I applaud you and the hospitals of this country for those figures. That means, as the bulk of the expenses are in-patient expenses, that out-patient costs have gone up appreciably, then, right?

Dr. THOMPSON. That is correct.

Senator SIMON. Thank you.

Senator QUAYLE. Good luck in catching your plane, and thank you very much.

Dr. THOMPSON. Thank you very much, Senator. I appreciate the opportunity to be with you this morning and enjoyed it.

Thank you.

Senator QUAYLE. Thank you very much.

Dr. Stone, let me just follow up on your point, there. In other words, I think what your bottom line is, there is that these students that receive medical education offshore, basically, that do not have that clinical education and that background, that there really is not any way in the long term that they are going to make that up, and on a qualitative basis, aren't you basically saying that those who are educated stateside have a higher quality than those who are educated offshore?

Dr. STONE. Yes, sir, but that is a belief.

Senator QUAYLE. Well, is it true?

Dr. STONE. I do not know whether it is true or not, but it is what I believe.

Senator QUAYLE. That is your belief.

Dr. STONE. Yes, sir.

Senator QUAYLE. And should we be concerned about that, assuming that your belief is true, about the increase in our number of physicians, and particularly in some of the hospitals that have as high as Dr. Relman pointed out, 60 percent of FMG's in their residency program; should that be a concern to us, to you, coming from the AMA, to us in the Congress, to oversee the Medicare/Medicaid Programs, to be very sensitive to the quality of care and to try to see that disbursed on as equitable a basis as possible?

Dr. STONE. Of course, I think we should be concerned. I guess from a personal point of view, I am also a pragmatist. We have a very substantial problem, and I think we need to accommodate to those individuals who have begun to participate in our health care system. In the clinical arena, we have got to provide them with the very best training and supervision we can, and to see that they have an opportunity to provide good health care, good medical care.

Senator QUAYLE. Would it be a worthwhile objective for us to try to get more physicians when they go out to practice in primary care than what we have today?

Dr. STONE. Well, not to quibble with you, I really do not think we have a good fix on how much primary care is being given. We need something analogous to the concept of an FTE, a full-time equivalent, rather than counting people generically, as to whether they are cardiologists or nephrologists or hepatologists or whatever kind of thing, because many of those individuals are giving really substantial amounts of primary care.

In addition, we have the whole issue of the increasing number of women in medicine whose activities are at a different level from what we have been accustomed to.

And then, I cannot resist saying that I happen to be associated closely, because our medical school is quite unusual—our clinical faculty is a multispecialty group practice, practicing in a semirural area in central Texas. It is the Scott & White Clinic. We are participating in profound changes, and we are not alone, in the way in which medical care is given in this country. Our clinic is actively setting up satellite groups all over, everywhere we can, and that is changing the way in which our specialists—if one talks about them that way—practice medicine. So I think there are—and I think Dr. Buchanan alluded to this, and Dr. Thompson, and others have—there are really subterranean changes occurring in medical care that are very subtle and hard to get a grasp on. They are hard to quantify, but they are nevertheless profound. And I think that those are going to be more influential in the end than are attempts at kind of a mechanistic approach to changing the numbers, generically changing the numbers of physicians.

Senator QUAYLE. So, in essence, what you are saying is that you do not necessarily subscribe to the proposition that it would be a beneficial thing for our society as a whole if more physicians coming into the system were primary care physicians rather than specialists.

Dr. STONE. Yes; I think we need more primary care physicians. I think we need to look at how they will function in the total system. You know, the whole gatekeeper concept is becoming current now. And I think that if we have primary care physicians who are part of a total system and are integrated into that system, that that will be a desirable way for many people to enter the medical care system. I think that is quite desirable.

So I would be reluctant to want to—being a strong believer in evolutionary processes—to set aside the rhetoric of the marketplace. We are dealing with evolutionary social change, and I think that is a very powerful process and one that is extremely wise, and I would like to see that operating.

Senator QUAYLE. I certainly subscribe to the point that we are in a period of a lot of changes in the whole health care industry, whether it is the physicians or the hospitals or whatever the case may be. Prospective reimbursement had a lot to do with a number of those changes, and we are seeing some other changes today, and that is why we are having this hearing today.

But I guess that, just listening to the testimony today, and we will be following this further, that as a general premise—and you sort of indicated that perhaps we need more primary care physicians—as a general premise, that we ought to focus and see what is going to happen in that arena. Now, we may disagree on how that

change ought to come about, and we can get into the market forces argument or the natural evolutionary process, or perhaps dynamics are presently in place that this will be a natural end result. But I think that is a basic premise or assumption that I would certainly begin with.

Another one that I would like to ask, and it is along these lines—do you subscribe to the belief that we do have a maldistribution of physicians within our system right now, meaning on a comparative basis of specialties versus primary care. And I do not want to get into, and as a matter of fact, am opposed to saying how many cardiologists on down the line, the specialties ought to be; I am certainly not coming from that premise. The basis of where I am coming from is just a general understanding of primary care physicians versus the other category of specialists.

Do you believe that there is perhaps a maldistribution there, not how we are going to correct it, but in fact, does it exist?

Dr. STONE. Senator, I have two knowledgeable colleagues with me who are chomping at the bit, I think, for an opportunity to express themselves. May I turn to Dr. Schwarz?

Senator QUAYLE. Sure, if you want to make a comment on that, and then Mr. Peterson, if you want to, also.

Dr. SCHWARZ. I am a Westerner, by birth, by training and by the majority of my career. I spent 10 years developing the WAMI Program in the Northwest, which is designed to create practitioners of a primary care variety to go into rural areas to practice. Specifically, in answer to your question is there a maldistribution, I think everyone would agree that there is.

I learned last week at the manpower conference at Duke University that there are three counties in North Carolina that we look on as sort of a bellwether of what you strive to achieve. There are three counties without physicians there. And some of the people in those counties feel they do not have adequate access to physicians in other counties. If you go to the west, there are still a variety of small rural towns that have inadequate numbers, or none at all.

So I think, at least from my vantage point, there is no question that there is maldistribution. And, as I sit here, I have the feeling of deja vu of the early seventies, when we were talking about shortage and maldistribution in this very room.

Senator QUAYLE. Well, deja vu is here.

Mr. PETERSON. If I could just add a brief comment with respect to AMA policies concerning the development of primary care physicians. My recollection is, going back to 1973 concerning hearings before this committee and others, the association's basic policy at that time was that a majority of those graduating from medical school should enter primary care residencies. That goal, which also became the goal of the Congress when it later enacted the capitation grants, has been achieved with respect to that number, and at the present time, my understanding is that approximately 64 percent of the medical school graduates are now entering the primary care residencies.

Senator QUAYLE. I think that is a fair figure that they are entering to that, but I think you will find out when it drops off dramatically is when they come out of the system, and that is a concern.

Mr. PETERSON. I understand.

Senator QUAYLE. Dr. Buchanan, you said that you had never witnessed in your years, I think, the disparity of preference among your colleagues on what kind of an alternative we ought to pursue in trying to get more responsiveness to the primary care issue. I suppose that hinges on about how we are going to achieve those goals, not whether, in fact, we ought to achieve those goals.

How does it break down? Give me a little dissertation of your private caucus that you may have and the real concerns that come about in your discussions, without divulging any confidentiality or things of that sort.

How does the discussion go in your inner sanctums?

Dr. BUCHANAN. Our committee has been in existence for 5 months, and we have recently been speaking with each of the subgroups of the Association of American Medical Colleges about the relevant issues as described in the "Statement of Issues," which you have.

There is, I believe, a growing concern and recognition of need to shift the mix of residency training positions further in the direction of primary care. However, I would have to say that many of the issues that Dr. Stone and others have raised have been elaborated on at length; namely, that what we really need to be certain about is that we have well-trained physicians. If a cardiologist is a cardiologist, he ought to also be able to take care of primary medical concerns, as well. Over-training may be wasteful in terms of societal resources, but over-training is not necessarily a bad thing from the point of view of providing entrance to the medical care system.

Now, that is an issue that is debated hotly by advocates of both sides. Some say once an individual becomes a specialist, he does not want to have anything to do with being an access physician, and others say you cannot survive as a cardiologist unless you have at least 40 percent of your practice in what I will call general medicine in most locations.

In any event, I think it is clear, and I can speak as a hospital director, that we increasingly need a broad base from which to draw our patients if we are going to maintain the activity levels of our institutions in a competitive environment. The presumption is that some institutions will not maintain that critical activity level.

When it comes down to whether you would limit the number of years of training, say, to 3 years, which would embrace virtually all of the so-called general specialties—internal medicine, family practice, pediatrics, and Ob-Gyn—or go the route of giving an individual assured training through the initial board eligibility, through some mechanism such as we have discussed, the GMENAC-type agency, one cannot get resolution of the debate and a consensus. At least, we have not been able to do so thus far.

Those who argue for funding for just 3 or 4 years of training say their plan will provide a sufficient disincentive for long-term training, and therefore, most individuals will elect to stop at that point where the assured funding runs out. I am not entirely certain about that. I am mindful of the fact that many medical students and young house officers today have unprecedented levels of debt. But I can also tell you, as a matter of ancient history, that when I

went into my residency program in 1954, we did not get paid anything, and I did 7 years—and I was not atypical.

I think it is not going to be determined solely by whether the dollars are available or not. I think certain things, like economic prospects, will be very important in the choice of individuals. Somebody might well persist through a 5- to 7-year period of training if he or she thought that such training significantly enhanced the economic prospects on the other end of the equation. This brings us to the point that one of the ways to get people into the primary care specialties, perhaps, is to look at whether or not the compensation for those individuals' once in practice is rationally relative to what many of the technical specialties have. Many of the technical specialties are very well paid. People are quite willing to go through long periods of training because the economic prospects on the other end are brighter.

If you go the other route and say no, we do not want to limit the number of years of training, but we want to fund everybody to primary board specialization or eligibility, then it is clear—and I think the committee is in agreement on this—that if you go that route, then you need some kind of an agency—national in scope, preferably in the private sector, which would make the allocation of the training spots from institution to institution, specialty to specialty.

I have heard you say, Senator Quayle, you really do not want to see that level of specificity. Maybe that is not necessary, but certainly, one would have to make a certain block kind of allocation of spots to the primary care specialties versus all others.

In looking at the figures, which we did do in our committee, once you go much above an output in the primary care specialties of 60 percent, you have to create a great many new primary care specialty training positions.

We have the figures on this. I do not have them in my head, but we do have them, because we have looked at them carefully.

Dr. STONE. Mr. Chairman, may I volunteer a comment?

Senator QUAYLE. Sure, Dr. Stone.

Dr. STONE. Thank you, sir.

Maybe it is self-evident, but what Dr. Buchanan is reflecting on is really the diversity among the medical schools, which I think is a good part of the discussion, although this issue of who controls, whether it is the hospital or the medical school, is another thing we ought to perhaps talk about a little bit.

But there is quite a diversity, and I guess if I would differ at this particular point with Bob, it is on the issue of where one might make a determination of influencing these distributional issues, whether it is at the State level or a national level. And you have heard both viewpoints expressed.

I really do think, without speaking to the issue of States' rights as some kind of a doctrinaire belief, that the State is the natural size of what we can manage; that that comes nearer to a manipulable unit, if one were to wish to influence distribution either by specialty or by geographic distribution. The States vary in many ways. For example, we have talked about the distribution of foreign medical graduates in the training programs. And the solution that is

appropriate for New York and New Jersey is certainly inappropriate for Texas, I believe.

So, we need somehow to find a balance between those two.

Senator QUAYLE. Dr. Buchanan?

Dr. BUCHANAN. Well, Bob, I spent 7 years in Senator Simon's home State, and I can tell you, when efforts to put physicians in some of the communities he mentioned were attempted, they were not successful if the individual simply wanted to be on the sunny shores of California or in the hustle-bustle of New York.

The economic issue of having some element of retirement of debt did not seem to be, at least in those days—it may be different now—but it did not seem to be between 1977 and 1983 a major influence in my experience.

Senator QUAYLE. Gentlemen, thank you very much.

[Additional material submitted for the record follows:]

National League for Nursing Ten Columbus Circle • New York, New York 10019-1350 • 212-582-1022
Virginia R. Jarrett, PhD, President Pamela J. Maraldo, PhD, Executive Director

March 28, 1985

Senator Dan Quayle, Chair,
Subcommittee on Employment and
Productivity,
Committee on Labor and Human Resources
428 Dirksen Building
Washington DC 20510

Dear Senator Quayle,

Attached are comments for you and your Committee members, to be submitted in the record of the hearings you held regarding Medicare Financing of Graduate Medical Education, on March 25, 1985. The comments are submitted on behalf of the National League for Nursing and the American Nurses' Association.

Rather than present oral testimony, we decided to address the nursing community s concerned through a written statement. We would be pleased to answer any questions you might have, and look forward to working with you and your staff in formulating a policy for Medicare's role in nursing education.

Sincerely,

Pamela Maraldo

Pamela Maraldo, Ph.D., RN
Executive Director

PM:gp

enc.

Comments Submitted for the Record of March 25, 1985

for Hearings by the

Subcommittee on Employment and Productivity,

Senate Labor and Human Resources Committee,

on the Subject of Financing of Graduate Medical Education,

by the

National League for Nursing and

the American Nurses' Association

The National League for Nursing (NLN) and the American Nurses' Association (ANA) commend you and your Committee for your attention to the subject of clinical education programs for the health professions. The NLN is the accreditation body for nursing education and includes 2,000 agency members and approximately 17,000 individual members; the ANA represents 185,000 registered nurses through 53 constituent state nurses associations. We are writing to share with your Committee the views of our organizations and request that these comments be included in the record of your March 25, 1985, hearings.

Your focus at these hearings and the proposals you have made address the post-graduate education of physicians. In several respects, however, the education of nurses and other health professionals must be considered as you evaluate health manpower needs and the most appropriate financing mechanisms for these programs. In fact, actions that may be taken with respect to physician education support could have very profound effects on nursing education in the hospital setting.

By way of background, it is important to recognize that Medicare payments for the direct costs of educational programs to teaching hospitals include funds for nursing education and the training of many other professions as well as the costs of graduate medical education (GME). At the time, there are little data available on the proportion of Medicare's payments that is applied to non-physician health professions programs. The NLN is currently conducting a survey of its membership to gain more precise estimates of the costs of clinical programs in nursing and the contribution made by Medicare. We intend to share these data with the Committee and other interested parties.

Meanwhile, we do know that the nursing component of overall Medicare educational payments to hospitals is proportionately small. Yet, these funds are critical to the financial viability of many programs. It would be unfortunate, indeed, for these clinical education programs in nursing and the allied health professons to lose or have reduced the Medicare contribution to direct educational costs because of policies designed for and aimed at GME programs. Conditions for future Medicare funding of GME should not apply to nursing education programs.

We understand that you and other Members have been considering new requirements for Medicare educational payments that relate to the proportion of training in certain medical specialties (e.g. primary care) or limits on the number of years in a program that would be eligible for financial support. These conditions are based on assessments of the physician needs of Medicare beneficiaries and opinions about the types of medical specialists that should be produced. We do not wish to speak to the appropriateness of these conditions. Rather, we want to underscore our belief that these matters are not germane to Medicare's policy on nursing clinical education programs.

There is, in view, not nearly so clear a consensus concerning the adequacy of the supply of registered nurses as there seems to be with respect to physician resources. On the contrary, we believe that in particular specialties and in the case of advance prepared practitioners, there are serious shortages and a maldistribution of nursing manpower. With the dramatically changing health system resulting in more acutely ill hospital

patients, an explosion in ambulatory health services, and a growing demand for post-acute and home care, it would be difficult to justify reductions in Medicare's funding of nursing education on the grounds of an oversupply of nurses.

Nursing, like other health professions, is going through a period of profound change adjusting to these new trends toward less hospitalization and more ambulatory and primary care practice settings. However, the types of changes that are likely and the responsiveness of the academic programs in nursing to changing consumer demands present a very different picture from that of the graduate medical programs. We would urge, therefore, that any conclusions about what Medicare should pay for physician education in the clinical setting be separate and distinct from policies that may be developed for nursing programs.

It is also important to note that hospitals with large graduate medical education programs do not always have large nursing education programs, and vice versa. Nursing and physician education programs are developed by different schools and are often operated by separate institutions with different goals and resources. They relate to each other by virtue of sharing the resources and responsibilities of a teaching hospital. Thus, a graduate medical education program in a hospital that fails to comply with Medicare conditions that may be imposed in the future could seriously jeopardize a nursing education program operating in the same institution.

Given these factors, the National League for Nursing and the American Nurses' Association urge that you apply your conclusions regarding Medicare payment toward graduate medical education only to those programs involving physicians, and continue to recognize and pass-through the costs of nursing and other health professons programs. If, at some point, your Committee wishes to review the future need for nurses, the types and extent of training that would be appropriate, and Medicare's responsible share of these costs, we would be glad to be of assistance.

amsa The American Medical Student Association Foundation

1910 Association Drive
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703 620 6600

April 8, 1985

Senator Quayle
Subcommittee on Employment and Productivity
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Quayle:

The American Medical Student Association appreciates your interest in graduate medical education and your recognition of important health manpower problems. We read, with great interest, your proposal for reform of graduate medical education. Enclosed you will find our views on this subject and a response to your proposals. Please notify us if you have any questions regarding our position or if we can be of any assistance to your subcommittee.

Sincerely,

Sharon A. Scanlon

Sharon A. Scanlon
Legislative Director

SAS:ji

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Testimony of the
American Medical Student Association
on
Graduate Medical Education

The American Medical Student Association (AMSA) is a national organization of over 30,000 medical students at 140 medical schools throughout the United States. AMSA is an independent organization of physicians-in-training committed to the improvement of medical education and health care delivery so that we, as practicing physicians, may better meet the health care needs of all the nation's people.

The American Medical Student Association is very interested in the problems of health manpower. In the past, we have supported federal efforts to increase the number of graduating physicians and a federal program that placed physicians in underserved areas. Presently, the nation is faced with a dramatic increase in the number of graduating physicians but no mechanism by which to ensure that they enter the medical specialties expected to be needed in the near future. We commend your efforts to address this problem and would like to share with the subcommittee our views on this subject and our response to the proposal outlined by Senator Quayle in the January 31, 1985 Congressional Record.

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Position Paper

Financing of Medical Education

- AMSA believes that adequate federal support for undergraduate medical education--in the form of institutional grants, federal capital contributions to revolving loan funds, scholarships, and loan guarantees--is essential if we are to ensure equal access to the health professions for lower to middle income families and minority students.
- AMSA supports the continued financing of graduate medical education through patient care revenues from third party payors including Medicare and Medicaid.
- AMSA strongly opposes any cuts in the funding of graduate medical education before studies identify what accounts for the added costs at teaching hospitals and what effect these cuts would have on patient care and medical education.
- AMSA believes that the federal government has an important and crucial role to play in health manpower planning. We believe that the financing of graduate medical education should be used to influence the specialty distribution of physicians.

Brief History of Federal Policies in Health Manpower

During the late 1950s and early 1960s, several government and private reports predicted an impending shortage of physicians. The enactment of Medicare and Medicaid in 1965 increased financial access to health care services for the poor and the elderly and resulted in an increase in demand for physician services. It was predicted that an increase in the aggregate number of physicians would be needed to meet this demand. Congress responded to this predicted shortage by enacting the Health Professions Educational Assistance Act of 1963 which provided funds for construction of new medical schools or expansion of existing ones, as well as low interest loans to medical students. This was followed by the Health Profession Education Act of 1965 which added federal scholarships and capitation grants.

These incentives for medical schools to expand were continued through 1981 and were very successful in increasing the physician training capacity of U.S. medical schools. They resulted in a growth from 87 medical schools graduating 7,300 physicians in 1963 to 126 schools graduating over 16,000 physicians in 1984.

During the early 1970s, the focus of attention changed from the number of physicians to the distribution of physicians. The establishment of the National Health Service Corp (NHSC) Scholarship program marked the beginning of federal initiatives designed to address this problem of maldistribution of physicians. Although the programs started out small, they took on major significance in the mid 70's. In 1976, the largest and broadest of Health Professions Legislation was passed (PL-94-484). Many strategies were implemented to improve the geographic and specialty distribution of physicians. This bill provided assistance for the establishment of family practice and primary care residency training programs, significant expansion of the NHSC scholarship program and a broadening

of the definition of underserved areas to include more urban areas, and an expansion of the area health education center (AHEC) program.

These programs have been successful in placing health care practitioners in underserved areas and in increasing the number of primary care physicians. The National Health Service Corp program has been very successful in making health care services more accessible in rural and inner city areas. Government support for primary care medicine is largely responsible for the growth and development of this specialty.

In 1980, several reports began to change the way that health manpower needs were viewed. The report of the Graduate Medical National Advisory Committee (GMENAC) stated that there would be a surplus of U.S. physicians by 1990 and a study by the Rand Corporation suggested that physicians were beginning to diffuse into previously underserved areas due to market forces created by a greatly expanded supply of physicians. These "facts" about the surplus of physicians and the diffusion into shortage areas were quickly incorporated as the basis of health manpower policy:

- Capitation funds to medical schools were totally eliminated in FY82 (causing medical school tuitions to skyrocket).
- Federal supplemental payments to the Health Professions Student Loan revolving funds ($16.5 million in FY1980) were eliminated in FY1985.
- National Health Service Corp Scholarships ($85.0 million in 1980 and $2.3 million in 1985) and Exceptional Financial Need Scholarships ($10.0 million in 1980 and $7.0 million in 1985) have been drastically cut and are targeted for elimination in 1986.
- The Administration is now proposing reductions in Medicare reimbursement for the direct and indirect costs of graduate medical education.

This new era of health professions assistance has been characterized by a reluctance on the part of the Federal government to subsidize medical education because "there are already too many physicians." There appears to be a suspicion that the provision of Federally subsidized aid for medical education will increase the number of physicians. This simply is not the case. Support for undergraduate medical education does not influence the number of students obtaining a medical education, rather it determines who is able to afford a medical education. Federal support for the direct costs of graduate medical education is actually reimbursement for patient care services. Budgetary freezes or cuts in graduate medical education would, again, not influence the number of doctors but could have very deleterious effects on residency training programs and on patient care.

Current Problems in Physician Manpower

- o Access to Medical Education for Low-income and Many Minority Students
- o Increasing Medical Student Indebtedness
- o Geographic and Specialty Maldistribution of Physicians

Recent changes in federal support for undergraduate medical education have resulted in skyrocketing tuitions, decreasing availability of low interest loans and scholarships and an increasing dependence on high interest loan programs. The average annual cost of a medical education at private schools is currently $19,200 and at public schools $10,750 for state residents. As the availability of low interest loans has declined, medical students have been forced to rely on what was originally designed to be the loan of last resort -- the Health Education Assistance Loan. This has resulted in a dramatic increase in medical student indebtedness. According to the AAMG Graduation survey, mean debt has almost doubled ($15,663 to $26,496) in the last five years and the fraction of students whose debt exceeds $50,000 has more than quintupled -- 1.5% to 8.1%.

The American Medical Student Association strongly believes that adequate financial support is essential in order to ensure access to a medical education for low income and many minority students. Society as a whole benefits from a diversity of economic, cultural and ethnic backgrounds represented in the medical profession.

The American Medical Student Association is very concerned about the potential impact of medical student indebtedness on the future specialty and geographic distribution of physicians. As medical students graduate with astronomical debts, they will be forced to enter the more lucrative subspecialties as opposed to primary care medicine.

All of these issues -- medical class size, the financing of medical education, physician reimbursement, and the specialty and geographic distribution of physicians are closely related. There are no simple answers to these problems but a few things seem very clear. One, the federal government is deeply involved in health manpower planning and has an important role to play. Two, we are at a crucial juncture in our health manpower planning. We now have an adequate number of physicians graduating but there are few, if any, incentives for them to enter the medical specialties where they are needed most. It seems entirely appropriate that the federal government continue to provide the incentives and regulations needed to influence the specialty distribution and geographic distribution of physicians in a positive manner.

Response to the Quayle Proposal

The American Medical Student Association is very interested in the proposal Senator Quayle made in the January 31, 1985 Congressional Record (pp. 5963-5965) for restructuring the financing of graduate medical education. In general, AMSA believes that the government should use Medicare funds as an incentive for reforming the graduate medical education system in order to make it more responsive to the health care needs of society. The following are specific comments or questions we have about the principles and steps outlined in Senator Quayle's proposal.

> "First, there should be an opportunity for every graduate of an LCME-approved U.S. medical school to compete successfully for a position in an approved and funded GME program."

The Association agrees that we need to ensure that each medical school graduate be able to complete their medical training in an approved and funded residency program. Due to our highly complex and technological health care system, medical graduates can no longer simply enter practice upon completion of a one-year internship. Three to five years of graduate medical education is necessary if physicians are to continue to provide high quality health care services.

It is equally important that these programs be adequately funded. After seven to ten years of college and medical school, medical graduates could simply not afford to work for little or no pay. Without adequate compensation for their services, young physicians would have to forego graduate training and would be forced to start practicing medicine before they are adequately prepared. This would seriously compromise the quality of care provided by American trained physicians.

"Second, there is no requirement that each graduate be able to receive training in the specialty of his or her choice."

The Association has given this issue a great deal of thought and attention. We believe that the type of residency positions available should match, as closely as possible, the expected health manpower needs of society. We realize that this will lead to a very limited number of residency positions in certain specialties and that graduates may not be able to obtain training in the specialty of their choice. However, we believe it is most important that we train the type of physicians expected to be needed in future years.

Specific steps proposed by Senator Quayle:

"First, a larger percentage of graduate physicians should enter training in the primary care specialties of internal medicine, pediatrics, family medicine, and obstetrics/gynecology."

AMSA has a long history of encouraging students to enter the primary care specialties and to practice in underserved areas. We agree that a larger percentage of physicians are needed in primary care. The federal government has a vital role to play in ensuring that we reach this goal.

When designing an appropriate mechanism to increase the number of primary care physicians, it is important to remember that almost half of all residents are in these primary care residencies. It is during residency training that many young physicians decide to pursue further training in the subspecialties. This is, at least in part, due to the better income potential and working hours of various specialties. Thus, when designing a method to influence specialty distribution, physician reimbursement as well as graduate medical education must be considered.

"Medicare should pay educational costs only when at least 75 percent of trainees in a GME program are graduates of an LCME-approved U.S. medical school."

AMSA believes that all graduates of an LCME-approved residency program should be able to complete their training at an approved and funded residency program. However, this does not mean that we can not also train foreign medical graduates (FMG's).

We have a number of questions regarding this proposal. One, what would become of the training programs that employ a large percentage of FMG's? Would these programs be able to attract American graduates? If not, would they be forced to eliminate their residency programs? What would this mean for the patients served by these hospitals?

"Third, education and patient care are completely interwoven in GME programs."

There is no doubt in our minds that the education of residents is closely intertwined with the treatment of patients. Any resident will testify to the fact that a significant amount of his or her time is spent in direct patient care.

The complex relationship between medical education and patient care is not easily defined and will not be elucidated by studies presently examining the direct costs of medical education. Medicare accounting methods do not and can not permit a precise separation of costs between education and patient care. This is because medical residents learn by caring for patients.

Conclusion

The American Medical Student Association is very pleased that you have decided to closely examine federal support of graduate medical education. We appreciate your concern for important health manpower problems and your willingness to address these problems. The American Medical Student Association welcomes proposals for reforming the graduate medical education system that would make it more responsive to the health care needs of society.

STATEMENT
OF
BLUE CROSS AND BLUE SHIELD ASSOCIATION

MEDICARE PAYMENT FOR GRADUATE MEDICAL EDUCATION

SUBMITTED TO THE

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY
COMMITTEE ON LABOR AND HUMAN RESOURCES

MARY NELL LEHNHARD
VICE PRESIDENT
BLUE CROSS AND BLUE SHIELD ASSOCIATION

APRIL 5, 1985

The Blue Cross and Blue Shield Association, the coordinating agency for the nation's Blue Cross and Blue Shield Plans, is pleased to present its views concerning payment for graduate medical education under Medicare. We understand that the Committee will be reviewing the Administration's proposal to reduce Medicare expenditures for graduate medical education which would involve freezing payments for direct educational costs and cutting in half the adjustment for hospitals' indirect teaching costs. These proposals, the Administration estimates, promise savings of $845 million in fiscal year 1986.

The Blue Cross and Blue Shield Association shares the Administration's concern for Medicare costs and the need to reduce the federal deficit. However, in our opinion, a freeze on the direct costs of graduate medical education and a halving of the indirect cost adjustment represent only a short term response and do not address the underlying issues. The Department of Health and Human Services has undertaken a major study of graduate medical education costs. We look forward to the findings of that study and would urge the Committee to consider them in any final action.

Teaching hospitals, through their graduate medical education programs, provide Blue Cross and Blue Shield Plan subscribers with a great deal of patient care, including specialized tertiary services. We believe that we have an obligation to pay for these services and their attendant costs when our subscribers use teaching hospitals. In order to recognize these costs, we negotiate with individual health care institutions.

The Blue Cross and Blue Shield Association believes that Medicare should continue to pass through the reasonable direct costs of graduate medical education, at least until better information provides for a more accurate assessment of the costs of patient care received through the graduate medical education program. We also believe that there should be an exploration of whether and how the direct costs of graduate education can be reduced without adversely affecting the quality of education or the quality of medical care.

We believe that the DRG payment mechanism should be refined to accurately reflect severity of illness differences. As the payment mechanism began to reflect patient care costs more accurately, the indirect adjustment might become unnecessary. We realize that the indirect adjustment is used by many teaching hospitals to offset the cost of care provided to indigent patients. Any sudden elimination of the adjustment could, therefore, adversely affect access to care by the poor. However, financing care for the poor and financing education costs are two separate issues. Each issue requires explicit attention. Therefore, we encourage a more specific addressing of the financing of care provided to the poor, and maintenance of the indirect adjustment until this problem has been resolved.

Payment for Direct Costs of Graduate Medical Education

Medicare's past commitment to graduate medical education has had a positive effect on the quality and stability of our medical education system. The pass-through method of payment has provided a predictable source of funds and has enabled medical educators to develop and maintain strong training programs. It has also allowed prospective students to know that the programs they undertake will retain their quality. This predictability of funding is important, and argues for continuation as an interim measure of the pass-through method of payment.

Ideally, Medicare should finance an appropriate share of the costs of education in the course of paying for the necessary care of beneficiaries. However, to achieve this goal, Medicare would have to develop data and methods to isolate and separately pay for those medical education costs that are truly related to the provision of necessary patient care. In determining the methods to pay for these necessary costs, Medicare should take into account the amount it would otherwise pay under Part B if the services were provided by physicians in non-teaching hospitals.

For so long as the direct payment of teaching costs is continued, it may be possible to reduce the cost of education without adversely affecting its quality or the quality of medical care. One approach might be for HCFA to consider establishing more stringent criteria for Medicare-approved medical education programs. For example, it has been suggested that each teaching hospital be required to have an affiliation agreement with a United States medical school that attests to the quality of the hospital's program. The effect would be to require that hospitals justify maintaining a GME program on the basis of the quality of education provided, and on the ability to attract qualified house staff. This approach to reducing the costs of medical education could be explored jointly by government, teaching hospitals, professional organizations and the medical schools.

Indirect Teaching Cost Adjustment

The indirect teaching cost adjustment is intended to offset costs incurred by teaching hospitals when students order extra tests and procedures, place extra demands on other staff and conduct more intensive treatment regimens as part of their education. Presumably, these costs are related not only to education, but to the characteristics of the patient population. Thus, a major argument for the teaching adjustment has been the higher costs associated with the sicker patients teaching hospitals treat.
The accuracy of the adjustment factor, based upon the relationship between operating costs per discharge and residents per bed, has always been debated. We share the Administration's skepticism regarding the accuracy of the adjustment. Doubling the adjustment may, in fact, have only magnified its inaccuracy. However, we would be equally concerned with arbitrarily reducing the total simply by cutting it in half.

The goal, obviously, is to contain indirect costs to the necessary level, and then to fund that level. The most promising alternatives to the use of an adjustment factor lie in measures to refine DRG prices. The more accurately DRG prices reflect the true costs of patient mix the less need there will be for adjustment factors for indirect costs of any magnitude.

Thus, we encourage continued study of severity of illness indicators and other means of rendering the payment system more sensitive to an individual institution's actual clinical load, retaining the incentives of prospective payment. There are few solid data on how the severity of case loads in teaching institutions compares with that of non-teaching institutions. In the absence of better severity indices some Blue Cross Plans have recognized severity through broader use of outliers. Medicare should consider a similar approach.

We understand that the indirect adjustment is used by many teaching hospitals to offset indigent care costs. We believe indigent care costs should be addressed explicitly. We do not see them as an appropriate function of the indirect adjustment. We do emphasize

that withdrawing the indirect adjustment without simultaneously addressing the financing of care to the poor could have a very adverse effect upon those hospitals which have a high percentage of patients unable to pay.

In conclusion, the Blue Cross and Blue Shield Association recommends that Medicare's commitment to medical education not be abandoned. We suggest that measures to limit payment for indirect costs be considered cautiously, with recognition that medical education is a long-term process, requiring long-term planning and resource commitment both by teaching institutions and by individuals. However, we do believe that it is appropriate to explore ways in which education costs can be reduced responsibly.

In summary, our position is that:

- The pass-through for direct medical education costs should be continued, at least until methods are available to price more accurately the patient care services such programs provide.

- The indirect adjustment should be maintained, as an interim measure, pending the development of means of dealing more precisely with differences in the clinical characteristics of hospitals' case loads.

- Any reliance upon the indirect adjustment as a means of financing care for the poor should be relieved by strengthening programs to pay explicitly for such care.

- It would be appropriate for government to work with teaching hospitals, the medical profession and others to explore ways of reducing the costs of graduate medical education without eroding its quality.

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STATEMENT OF THE

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY

OF THE SENATE LABOR & HUMAN RESOURCES COMMITTEE

ON

GRADUATE MEDICAL EDUCATION FUNDING

March 25, 1985

Introduction

It is a pleasure to present the views of the American Osteopathic Hospital Association (AOHA), the national organization representing the more than 200 osteopathic hospitals, on issues pertaining to medical education - the most critical policy area facing our profession. We commend Senator Quayle for his leadership role on this issue.

Osteopathic Hospital Profile

Osteopathic hospitals serve as the primary institutional care facilities for those individual consumers who choose to receive their care from over 22,000 practicing osteopathic physicians in the United States. Osteopathic hospitals have nearly 25,000 beds available and in 1983, treated about 845,000 inpatients and nearly 4 million outpatients. In this era of competition, osteopathic medicine represents the only recognized comprehensive alternative to traditional medical care.

Our institutions and medical profession emphasize wellness and preventive care resulting in a "patient oriented approach" to medical treatment. Osteopathic hospitals provide a health care choice to the American people based on a distinctive medical philosophy offering patients a personalized, wholistic, "hands on" approach. With many of our hospitals located in rural and semi-rural areas, and with nearly half of our institutions having less than 100 beds and 80% having less than 200 beds, the osteopathic hospital profile reflects a very special community orientation. The fact that nearly 90% of practicing osteopathic physicians deliver primary care with half practicing in communities of less than 50,000 persons, is further evidence that

our profession is on the cutting edge of community health care needs. With this backdrop, it is our pleasure to convey to the Subcommittee the trends we see developing in osteopathic teaching hospitals; a description of the osteopathic model; an explanation of the vital role medical education plays in our hospitals; and, the effects of current Medicare policy on the osteopathic teaching institution. We will also present our evolving thoughts on Senator Quayle's proposal to reform graduate medical education policy.

The Osteopathic Teaching Hospital

The training of tomorrow's general practitioners and family physicians is a top priority for osteopathic hospitals. Federal policy regarding the treatment of medical education costs was the Association's major policy concern during the deliberations on Medicare prospective payment and continues to be today. The reason for this is evident when examining the role osteopathic hospitals play in training osteopathic physicians. Of the more than 200 osteopathic hospitals in the United States, 111 are osteopathic teaching institutions. The overwhelming majority of the hospitals are community facilities and not academic health centers. In fact, all of our community hospitals with 200 - 299

beds are teaching institutions, while 70% with 100 - 199 beds have teaching programs. Only four of the fifteen osteopathic medical colleges currently operate teaching hospitals.

When considering policy regarding the financing of medical education under Medicare, AOHA believes that the needs of the smaller community hospital with a teaching emphasis should be reflected.

The Osteopathic Teaching Model

The osteopathic teaching hospital role in training general practitioners and specialists begins during the osteopathic medical student's undergraduate training. Our educational model stresses clinical exposure through externships and clinical clerkships. This type of hands on clinical education is an essential ingredient to train the osteopathic physician. As recent news reports have indicated, traditional medical education is being criticized for not emphasizing "hands on" exposure. Unfortunately, current federal policy is already having a negative impact on the further development of these needed clinical experiences. The Health Care Financing Administration has defined

such clinical training of students enrolled in medical education programs as a normal operating expenditure of hospitals. Thus, the funding of such undergraduate clinical clerkships must be supported directly from the prospective payment rates. With the census dropping in osteopathic hospitals nationwide, and pressures to curtail certain services growing, our institutions are finding it increasingly difficult to support these essential undergraduate medical programs.

The osteopathic hospital has traditionally had primary responsibility for conduct of internships and residencies. Under the osteopathic graduate medical education model, all osteopathic physicians must engage in a one-year rotating internship during which they receive clinical exposure in a multitude of medical areas. This builds the foundation for the general practitioner - the backbone of the osteopathic profession. Completion of the rotating internship allows an osteopathic physician to practice general medicine under all federal statutes and all state statutes with the exception of New Hampshire, where two years of post-graduate training is required for all physicians.

Residency training, especially in the primary care specialties, is playing an increasingly important role in our teaching hospitals. While our general practice model consists of a one-year rotating

internship followed by a one-year residency, other specialties require from two to six years additional training. The average length of osteopathic residency programs is 2.5 years.

Last year there were 1,408 approved osteopathic intern positions and 1,688 approved residency training positions. These positions are approved by the Bureau of Professional Education of the American Osteopathic Association (AOA), the accrediting arm of our profession.

The Intern "Crunch"

The osteopathic profession is now facing a crisis regarding the long term ability of our osteopathic teaching hospitals to provide the necessary intern and residency programs needed for our new physicians. Our hospital system is not growing and, in fact, will likely be reconfigured as the pressures of Medicare and other financing programs take further hold. Osteopathic hospitals are faced with the dilemma of reacting quickly to external demands to constrain programs while meeting an increasing demand to train needed osteopathic physicians. This has resulted in an intern "crunch" in our hospitals.

Historically, about 6-7% of AOA approved intern positions nationally remain unfunded in our hospitals. In 1984, that figure reached 13% due to declining census, shorter lengths of stay, a shift toward ambulatory services and concerns about future funding. Our profession is attempting to work out these problems within the osteopathic family, but the options are limited. Obviously, any federal or state policy initiatives that limit payment for teaching purposes will further exacerbate our problems.

Current Federal Policy

Under the present Medicare prospective payment law, osteopathic teaching hospitals are treated no differently than other teaching hospitals. It is really too early to fully evaluate how the current payment system is working in our hospitals, however, the effect on graduate medical education is being felt. In order to remain competitive, it is becoming increasingly difficult to provide quality internship programs with a significantly reduced census and an inadequate case load for teaching purposes.

The Association continues to support the exclusion of direct medical education expenses from the prospective payment system and the additional payment for indirect education expenses. We

believe that this adjustment is still needed for the same reasons that the Congress saw fit to include it when enacting the prospective payment system. Tests and procedures ordered by interns and residents, the demands placed on other staff as they participate in the education process, and other related expenses continue to be legitimate costs.

AOHA believes that any change in federal policy should await further study. Hopefully, the five-year federally funded study of the cost of graduate medical education currently underway will be helpful in evaluating these issues. One question the study may answer is how well current case mix indexes measure the severity or intensity of cases treated in teaching hospitals. While severity of cases should be a factor in determining whether teaching hospitals should be treated differently under any payment system, we do not believe it should be the only criterion. Our hospitals are community institutions, and ninety percent of our physicians are being trained in primary care. Federal policy emphasizes the need for primary care physicians. We feel the training we are providing is consistent with that aim and should be reflected in any formula for payment to teaching hospitals.

Perspectives on Senator Quayle's Policy Options

During this early examination of possible alternatives to the current reimbursement formula for graduate medical education, AOHA would like to offer our preliminary perspectives on Senator Quayle's policy thrust.

The emphasis on the training of primary care physicians is consistent with the philosophy and performance of the osteopathic profession. To repeat, nearly 90% of practicing osteopathic physicians deliver primary care. The majority of our primary care physicians are general practioners. A policy that recognizes this objective and the performance of osteopathic medicine in achieving it, is a positive development.

AOHA also agrees with you that it would be inappropriate to separate GME financing from hospital payments for providing patient services. We support your belief that Medicare should continue to pay its fair share of the costs of graduate medical education.

While the osteopathic profession's reliance on primary care training is consistent with your approach, aspects of the January 31, 1985 proposal are inconsistent with our teaching model. Our

GME programs are not conducted in hospitals holding membership in the Association of American Medical College's Council on Teaching Hospitals. Rather, our teaching hospitals belong to the American Osteopathic Hospital Association. Our 15 medical colleges are not approved by the Liaison Committee on Medical Education. The American Osteopathic Association (AOA) Bureau of Professional Education is the federally recognized accrediting body of our colleges. AOA is recognized by all appropriate bodies for accrediting purposes. AOA also accredits our hospitals and postdoctoral training programs. It is recognized by Congress and the Department of Health and Human Services for Medicare participation.

AOHA suggests that in order to be consistent with other statutes and practices, the requirement that 75% of trainees in a GME program graduate from an LCME approved U.S. medical school be amended to add AOA accredited schools. This is further warrented by your proposal's objective to limit support for foreign medical graduates (FMG's). This is not an issue for osteopathic hospitals since FMG's play no role in our institutions. All of our interns and residents are graduates of one of the 15 American osteopathic medical colleges.

Your proposal to require all teaching hospitals to have an affiliation agreement with a medical school to be eligible for Medicare funds is being met by most osteopathic hospitals in various ways. Our community teaching hospitals and medical colleges are mostly independent entities working in concert through working agreements and arrangements. However, our primary care orientation negates the need for colleges to negotiate with osteopathic hospitals to reallocate positions.

Another point raised concerns the necessity for a body similar to the Graduate Medical Education National Advisory Council to monitor data and recommend the percentage of positions to be allocated to primary care. AOHA feels that the market place, consumer choice and decisions regarding federal payment policy will result in the desired outcome. Another federally appointed body setting rigid requirements will prove counter productive.

Conclusion

The American Osteopathic Hospital Association urges that the osteopathic training model be considered in any future deliberations on these critical issues. We strongly feel that our teaching programs are producing the types of physicians that this country needs. The emphasis on primary care and providing service

in medically underserved areas is a historical role of the osteopathic teaching hospital. We hope the Subcommittee will consider how our alternative medical system is providing a real health care choice for the American people.

We thank you again very much for the opportunity to present our perspectives on this critical issue.

Senator QUAYLE. With that, the hearing is adjourned.
[Whereupon, at 12:50 p.m., the subcommittee was adjourned.]

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